pediatric dental center
professional corporation
29421 Ryan Road
Warren, MI 48092
(586) 754-6300
pdconline.com

KIDS SMILES... PEDIATRIC DENTISTRY

48621 Hayes Rd.
Shelby Park, Bldg. 500
Shelby Twp, MI 48315
(586) 247-5437 (KIDS)
kspdonline.com

PATIENT INFORMATION

CHILD'S FULL NAME: _____ NICK NAME: _____

CHILD'S BIRTH DATE: _____ AGE: _____ SEX: (Circle) M F

CHILD LIVES WITH: (Circle) **Both Parents** **Mother** **Father** **Guardian** **Grandparents**

CHILD'S HOME ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

ALTERNATE NUMBER - Emergency

(Friend, neighbor, relative, etc.)

Name: _____ Relationship to Child: _____ Phone: _____

REFERRAL SOURCE

We appreciate the referral of patients to our office and like to send a special "thank you". Whom may we thank for referring you to us?

Name: _____ Relationship: _____

PARENT INFORMATION

FATHER'S FULL NAME: _____

Father Employed By: _____

Social Security #: _____

Driver's License # _____

Employer Phone #: _____

Birth Date: _____

MOTHER'S FULL NAME: _____

Mother Employed By: _____

Social Security #: _____

Driver's License #: _____

Employer Phone #: _____

Birth Date: _____

DENTAL INSURANCE INFORMATION

Insured Party's Name: _____

Employer: _____

Group #: _____

Contract # _____

Relationship to Child: _____

Insurance Co.: _____

Insurance Phone #: _____

IF MORE THAN ONE INSURANCE COVERAGE, PLEASE COMPLETE:

Insured Party's Name: _____

Employer: _____

Group #: _____

Contract #: _____

Relationship to Child: _____

Insurance Co.: _____

Insurance Phone #: _____

Payment for services is required at each appointment.
The adult who brings the child to the office is financially responsible.

It is your responsibility to inform us of any changes in your child's health. Thank you.

Family Physician or Pediatrician: _____ Phone: _____

MEDICAL HISTORY

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
ADHD			Counseling			Kidney Disorder		
AIDS or HIV Positive			Cystic Fibrosis			Muscular Dystrophy		
Acid Reflex / GERD			Developmentally Impaired			Motor Skills Delayed		
Artificial Prosthesis			Diabetes			Premature Birth		
Asthma			Drug Allergy			Radiation Treatment		
Attention Deficit Disorder (ADD)			Eating Disorder			Rheumatic Fever & Heart Disease		
Autism/Autism Spectrum Disorder			Epilepsy			Seizures		
Birth Defect			Hearing Impaired			Shunt		
Bleeding Disorder / Anemia			Heart Disorder / Surgery			Speech Delayed		
Blood Transfusion			Heart Murmur			Surgery		
Brain / Nerve Damage			Hepatitis / Liver Disorder			Tuberculosis		
Cerebral Palsy			High Blood Pressure			Vision Impaired		
Chemotherapy			Hyperactivity			Other _____		

Please explain any YES answers
or other health problems: _____

Is your child allergic to: ☐ Penicillin ☐ Erythromycin ☐ Ceclor ☐ Sulfa ☐ Amoxicillin ☐ Medicine ☐ None Known
☐ Food ☐ Environmental ☐ Other / List: _____

1. Is your child being seen by a physician? (Circle) YES NO If yes, why _____

2. Is your child taking any medicine now: (Circle) YES NO List: _____

DENTAL HISTORY

3. Does your child have a toothache now? (Circle) YES NO Where: _____

4. Any previous dental experience? (Circle) YES NO Where: _____

5. What was done:_____ When: _____

6. Child's reaction:_____ Parent's reaction: _____

7. Inherited dental characteristics: _____

8. Main dental concerns or reason for today's appointment?: _____

9. Any injuries to front teeth? (Circle) YES NO When: _____

10. Has your child ever had injuries to the head or neck? (Circle) YES NO

11. Does your child have any oral habits? (Circle) Thumb Finger Pacifier Other: _____

12. Who brushes your child's teeth? _____ When: _____

13. Name and ages of other children in the household: _____

DIETARY HISTORY

14. Do you have fluoride in your drinking water? (Circle) YES NO

15. Does your child snack frequently? (Circle) YES NO On what? _____

16. Does your child drink juice frequently? (Circle) YES NO What kind? _____

17. Do you help your child floss daily? (Circle) YES NO

18. Does/did your child take a bottle to bed? (Circle) YES NO Explain: _____

Because your child is a minor, signed permission is required from a parent or guardian for any dental treatment.

Signature of parent or guardian: _____ Date: _____

Reviewed by: _____ Date: _____