Emhardt Pediatric Dentistry, LLC

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New Patient Information

Thank you for choosing Emhardt Pediatric Dentistry for your child's dental care!

Patient Name: _____ **Preferred Name**: _____

Gender: M / F **Birthdate**: ____/____/_____ **Email**: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Mobile Phone: (____) ____-_____ **Home Phone**: (____) ____-_____ **Best Time to Call**:_____

Who is accompanying the child today or is expected to on the date of their appointment?

Name: _____

Please Circle: Biological Adoptive Foster Nanny Other: _____

Please list any siblings that are current patients here at our office:

_____

Emergency Contact/Phone/Relation (other than parent)

Name: _____ Phone: (____) ____-_____ Relation: _____

Is your child a ward of the state: Yes / No **If yes, case worker's number** (____) ____=_____

Is there anything you would like to discuss with the Dentist in private, alone, or away from your child? Yes / No

What is the reason for seeing the dentist today? (please circle)

First Visit Cleaning Trauma/Dental Emergency Consult for Decay Other: _____

Whom may we thank for referring you to our Practice? (Please circle and name below)

Another Dental Office Pediatrician/Doctor Phonebook Friend Social Media Driving By Google

Insurance School/Day Care Sibling(s) Website Media Ad Work

Community Event Other: _____

Parent Information

Name: _____ Preferred Name: _____

Gender: M / F Family Status: (please circle) Married Single Other

Birthdate: ____/____/_____ SS#: ____-____-_____ DL#: _____

Mobile: (____) ____-_____ Home: (____) ____-_____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Dental Benefits

Name of Primary Insured: _____

Patient's relationship to insured: (please circle) Self Child Other: _____

Employer of insured: _____

Birthdate of insured: _____-____-_____ SS# of insured: _____-_____-_____

Plan's phone number: (____) ____-_____

Consent for Services and Financial Agreement Policy

To the best of my knowledge, all of the preceding information is true and correct. If there are any changes in my child's health I will inform the office at my child's next dental appointment.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health.

I authorize the dentist to release my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnoses and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice, to be applied to my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on behalf of my child(ren)/dependents.

Relationship to Patient (please circle): Mother Father Guardian Other

Signature: _____ Date: ____-____-_____

Child's Medical History

Child's Pediatrician: _____ **Phone**: (____) ____- _____

Is your child followed by a specialist: Yes / No **Name**: _____

What is the approximate date of your child's last medical exam: _____

Current Medications: _____ **Are Immunizations current**? Yes / No

Does your child have any allergies (please specify below) Drug Food Seasonal Hives Latex Other

List Allergies: _____

Preferred Pharmacy: _____ Phone: (____) ____-_____

Please indicate if your child has experienced any of the following:

Y / N Acid Reflux	**Y / N** ADD/ADHD	**Y / N** AIDS/HIV Positive	**Y / N** Anemia
Y / N Aneurism	**Y / N** Arthritis	**Y / N** Artificial Joints	**Y / N** Asthma
Y / N Autism Spectrum	**Y / N** Bleeding Disorder	**Y / N** Blood Transfusion	**Y / N** Cancer/Tumor
Y / N Cerebral Palsy	**Y / N** Cleft Lip/Palate	**Y / N** Cold Sores	**Y / N** Cystic Fibrosis
Y / N Developmental Delays	**Y / N** Diabetes	**Y / N** Dizziness	**Y / N** Down Syndrome
Y / N Eartubes	**Y / N** Eating Disorder	**Y / N** Eczema	**Y / N** Epilepsy
Y / N Excessive Bleeding	**Y / N** Fainting	**Y / N** Febrile Seizure	**Y / N** Glaucoma
Y / N Head Injuries	**Y / N** Hearing Aid	Y **/ N** Hearing Impairment	**Y / N** Heart Disease
Y / N Heart Murmur	**Y / N** Hemophilia	**Y / N** Hepatitis	**Y / N** Hernia
Y / N Herpes	**Y / N** High Blood Pressure	**Y / N** HIV	**Y / N** Hospitalized
Y / N Jaundice	**Y / N** Kidney Disease	**Y / N** Liver Disease	**Y / N** Mental Disorders
Y / N Mitral Stenosis	**Y / N** MVP	**Y / N** Nervous Disorder	**Y / N** Other
Y / N Pacemaker	**Y / N** Physical Disability	**Y / N** Pregnancy	**Y / N** Premature
Y / N Radiation Treatment	**Y / N** Respiratory Problems	**Y / N** Rheumatic Fever	**Y / N** Rheumatism
Y / N Sickle Cell Trait	**Y / N** Sinus Problems	**Y / N** Speech Disorder	**Y / N** Stomach/GI Disorder
Y / N Stroke	**Y / N** Tonsilitis	**Y / N** Tuberculosis	**Y / N** Tumors
Y / N Ulcers	**Y / N** Venereal Disease	**Y / N** Vision Problems	

If any of the previous questions are marked, please explain: _____

Any other conditions, diseases, etc, not listed above: _____

History of hospitalizations/operations/emergency room care/recent illness: _____

Tobacco use (chewing or smoking): _____ How long: _____

Child's Dental History

Has your child been to a different dental office in the last 6 months? Yes / No

If Yes, Office Name: _____ Phone: (____) ____-_____

Date of last dental exam: _____ **Date of last x-rays**: _____

Do you think your child will react well to treatment? Yes / No

Please describe any tips/tricks that will help our team provide a positive experience for your child's visit:

_____

Has your child had complications with or after dental treatment: Yes / No

If yes, please explain: _____

How frequently does your child brush their teeth? (please circle)

3+ a day Twice a day Once a day Weekly Seldom

Who brushes and flosses your child's teeth? (please circle) Parent Child/Self Both

How often does your child floss? (please circle) Once Daily Occasionally Never

Does your child do any of the following? (please circle)

Lip sucking/biting Pacifier Nail biting Finger/thumb sucking Nursing/bottle Grinds teeth Snoring

I have filled out the above medical/dental history and agree to their content:

Signature: _____ **Date**: ____-____-_____