PEDIATRIC DENTAL CARE OF RHODE ISLAND

Welcome to Pediatric Dental Care of RI

Patient Registration and Health History

Patient Name (Last, First, MI): _____ Nickname: _____
DOB: _____ Age: _____ Weight: _____ Gender: _____ School: _____
Full Home Address: _____Grade _____
How did you hear about us? _____

Family Information

Name of Person Completing This Form: _____ Relationship: _____
Are you a parent or legal guardian? Yes/No Please circle one: Parent/Guardian/Foster
Adult Marital Status (please circle one): Single/ Married/ Separated/ Divorced/ Widow/ Other
With whom does this child live? (please circle one): Parent/ Family Member/ Foster/ Other
Names/Ages of other siblings we treat: _____

Mother/Caregiver's Information

Name: _____
Relationship: _____
DOB: _____ SS#: _____
Home#: _____ Cell#: _____
Employer Name/Address/Phone: _____
_____
Email: _____

Father/Caregiver's Information

Name: _____
Relationship: _____
DOB: _____ SS#: _____
Home#: _____ Cell#: _____
Employer Name/Address/Phone: _____
_____
Email: _____

Primary Dental Insurance

Coverage Name: _____
Address: _____
Group/Policy#: _____
Phone# _____
Policy Owner's Name: _____
DOB/SS#:_____

Secondary Dental Insurance

Coverage Name: _____
Address: _____
Group/Policy#: _____
Phone#: _____
Policy Owner's Name: _____
DOB/SS#: _____

Person Responsible for Account

Name: _____ Relationship to Child: _____
Primary Phone# _____ Address: _____

Payment of fees for professional services is expected at time of treatment by parent/guardian in attendance. We can file insurance claims for you and accept assignment of patient to our office. We follow HIPAA privacy rules to keep your information confidential. *I have read and understand this form completely and hereby assign/authorize payments and the release of any medical information necessary to secure patient to this office for services rendered on my behalf.

Signature of Parent/Guardian: _____ Date: _____

Health History

It is important this is filled out as accurate as possible. Many conditions/medications that affect your child's oral health

Patient's Name: _____

Dental History

Is this your child's first visit to the dentist? Yes/No Previous Dentist Name: _____

What brings you to the dentist today? _____

Any history of trauma to face or teeth? Yes/ No _____

How would you describe your child's behavior and feelings at the dentist (please circle any of the following):

Good / Fair / Bad / Excited/ Curious / Anxious / Fearful / Indifferent / Unsure / Unknown

Anything that will improve your child's visit? Y/N_____

Is your child's water fluoridated? Yes/ No/ Unknown Water source: Town Water/ Well Water/ Bottled

Does your child use fluoridated toothpaste? Yes/ No _____

Please Check and Circle all Subcategories that Apply:

These may apply to the past or present

	Clenching/Grinding Teeth		Mouth Breathing		Chews non-food objects
	TMJ/ Jaw Pain or Clicking		Lip Biting/ Sucking		Snoring
	Thumb/Pacifier/ Finger Habit		Nail Biting		Not brushing 2x per day/Flossing
	Sleeps with a Bottle		Tongue Thrust		Dry Mouth
	Early Childhood Decay		Frequent Snacking		Cold Sores or Canker Sores

Other:

Medical History

Primary Care Physician Name/Practice: _____

Phone #: _____ Last Visit: _____ Up to date on Vaccines? Yes/ No _____

Does your child have ANY ALLERGIES including seasonal/medications/ dyes/ foods, or other? Yes/ No

If yes, please List: _____

Please List **ALL MEDICATIONS** your child is currently taking: _____

Has your child had any unexpected reactions to amoxicillin, penicillin, numbing anesthetics, of general anesthesia?

Yes/No. _____

Does your child have/had any of the following medical conditions? (Check/ Circle all that apply/Fill in additional in blank):

	Abnormal Bleeding/ Anemia		Celiac/Colitis/ Digestive Issues		Migraines/ Headaches
	ADD/ ADHD/ OCD		Cancer/Chemo/Radiation Therapy		Mental Health Issues
	Anxiety/ Depression		Diabetes		Pregnancy
	Artificial Bones/ Joints/ Valves		Epilepsy/Fainting/Seizures		Pacemaker
	Asthma/ Persistent Cough		Eating Disorder (Anorexia/ Bulimia)		Shunt
	Autism/ SPD/ ODD		Eczema/ Skin issues		Special Needs
	Acid Reflux		Ehlers Danlos Syndrome		Tuberculosis
	Blood Diseases or Disorders		HIV/ AIDS		**ANTIBIOTIC PREMEDICATION**
	Chicken Pox/Measles/Mumps		Hearing Impairment		**NO KNOWN CONDITIONS**
	Congenital Heart Defect/ Murmur		Kidney/Liver Issues or Disease		
	Cleft Lip / Craniofacial Deformity		Lactose Intolerance		

Explain: _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in strict confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform all necessary dental services for my child. I will not hold my dentist, or any member of his staff responsible for any errors or omissions that I may have made in completing this form.

Signature of Parent/Legal Guardian _____ Date: _____

Signature of Dentist: _____ Date: _____