Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Caldwell and Steinbring, D.D.S.

Tell Us About Your Child

Today's Date _____

Name _____

Preferred Name _____ ☐ Male ☐ Female

Child's Birth date ___/___/___ Child's Age _____

Child's Home Address

_____
Apt/Condo #

_____
City State Zip

Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? ☐ Yes ☐ No

Is your child adopted? ☐ Yes ☐ No

Other family member(s) seen by us _____

Parent's Marital Status ☐ Single ☐ Widowed
☐ Married ☐ Divorced ☐ Separated

Please circle the phone number that you would like us to call or text to confirm all appointments.

Mother's Information ☐ Step-Mother ☐ Guardian

Name _____

Work# _____ Ext ____ Home# _____

Employer _____

Cell# _____ SS# _____

Date of Birth _____

Must have one social security number on file for our billing purposes.

Father's Information ☐ Step-Father ☐ Guardian

Name _____

Work# _____ Ext ____ Home# _____

Employer _____

Cell# _____ SS# _____

Date of Birth _____

Name of Nearest Relative

Name _____

Work# _____ Ext ____ Home# _____

Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

Relationship to Patient _____

Insured's Birth date ___/___/___ ID# _____

Insured's Employer _____

Please provide us with your *E-MAIL ADDRESS*: This is how we send appointment reminders.

_____

Would you like to receive email statements?

☐ **Yes** ☐ **No**

How did you hear about our office?
(please check all that apply)

☐ Pediatrician _____

☐ Orthodontist _____

☐ General Dentist _____

☐ Magazine Ad _____

☐ Tillie Program; School _____

☐ Friend _____

☐ Insurance _____

☐ Internet _____

☐ Other _____

_____

_____

Medical History

Reason for today's visit _____

Has the child ever had a bad experience with dental work? ☐ Yes ☐ No

Is the child ***Delayed Average Advanced*** in social development? Please circle one.

How would you describe the child's personality/temperament? Circle all that apply:

Cooperative Uncooperative Sensitive Apprehensive Well-adjusted Aggressive Shy

Previous dentists' name and phone number _____

Last Date Seen _____ X-rays _____

Is your child's drinking water fluorinated? ☐ Yes ☐ No

Is your child taking vitamins with fluoride supplements? ☐ Yes ☐ No

How many times a day are your child's teeth brushed? _____

Is the child currently using a bottle? ☐ Yes ☐ No How often? _____

Current dental habits. Please circle: ***Thumb or Finger Sucking Use of Pacifier Lip or Cheek Biting Nail Biting***

Previous or current TMJ (jaw) pain, tenderness or popping? _____

Does the child have or ever had recurring headaches? ☐ Yes ☐ No

Has the child ever had any of the following medical conditions? Please circle all that apply.

Y N Cancer/Tumors
Y N Asthma/Breathing Problems
Y N Congenital Heart Defects
Y N Gastro Intestinal Problems
Y N Diabetes
Y N Frequent Infections
Y N Hepatisis
Y N Rheumatic Fever
Y N Liver Or Kidney Disorder
Y N Seizures/Epilepsy
Y N Endocrine System
Y N Hemophilia/Bleeding Disorders
Y N Tuberculosis
Y N Sight Impairments
Y N Lung or Respiratory Problems
Y N HIV/AIDS
Y N Hearing Impairments

History of blood transfusions? ☐ Yes ☐ No Date _____

Does the child have a heart murmur or condition that requires ***Prophylactic Antibiotic coverage for dental work?***
☐ Yes ☐ No

Please list all medications the patient is currently taking _____

Please list any medical conditions that the child has had past or present _____

Hospitalizations or injuries _____

Please list all drugs the child ***is allergic to*** _____ Other allergies _____

Does the child have seizures? ☐ Yes ☐ No Are the seizures related to high fever? ☐ Yes ☐ No

Does the child have any behavioral or learning disabilities? _____

Developmentally Delayed? ☐ Yes ☐ No Skill Level _____

Physical Disabilities _____

Any other significant problems or comments _____

_____

Has the child had any recent infections of bacterial or viral origin? ☐ Yes ☐ No

Is your child currently under the care of a physician? ☐ Yes ☐ No

Child's Physician _____ Phone _____Date Last Seen _____

Because your child is a minor, it is necessary that signed permission be obtained from a parent or guardian before and/or all necessary dental treatment is performed. Diagnosis of services needed and financial obligations will be discussed with you by the doctor and/or staff before treatment is rendered. Your signature authorized Dr. Caldwell and/or his Pediatric Dentist Associate to render necessary dental treatment, to administer anesthetics, to administer medication, to take radiographs (X-rays), clinical photographs, study models and other records necessary for an accurate diagnosis, to utilize behavior management therapy as needed to provide safe dental care for your child and employ such assistance as is appropriate.

Signature of parent or guardian _____ Date _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CEC and the ADA.

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Initials____ Date _____

Doctor's Comments _____