Uptown Dental

Mathias & Olson

Patient Name: _____
Nickname: _____
Birth Date: _____ **Age:** _____
Gender: M F

Mother's Name: _____
Birth Date: _____
Employer: _____
Cell Phone: _____ **Work Phone:** _____
Home Phone: _____
Email: _____
Address: _____

Father's Name: _____
Birth Date: _____
Employer: _____
Cell Phone: _____ **Work Phone:** _____
Home Phone: _____
Email: _____
Address: _____

Who is the child's legal guardian?

_____

Where is the child's primary residence?

_____

INSURANCE INFORMATION

Name of Insured: _____
DOB _____/_____/_____ **SSN:** _____
Employer: _____
Insurance Carrier: _____ **Group** _____

HEALTH HISTORY

Child's Physician: _____

Preferred Pharmacy: _____

Y N Is your child in good health?
Y N Has your child ever had a health problem?
Please list: _____

_____

Date: _____

Y N **Has your child ever been hospitalized or had any surgical procedures (reasons & dates)?**

_____

_____

Is your child allergic to any medications or foods?
Please list: _____

Is your child taking any medications? Please list:

_____

Were there any problems at birth? _____

_____

Do you consider your child's development to be?
advanced normal slow

Please indicate if your child has a history of:
(Please elaborate on any items checked):

- ☐ Adopted
- ☐ Asthma/Reactive Airway
- ☐ Autism/PPD
- ☐ Bleeding/Blood Transfusions
- ☐ Cancer/Tumors
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Palate
- ☐ Congenital Defect
- ☐ Down Syndrome
- ☐ Ear Infection/ Tubes
- ☐ Eyes/Vision
- ☐ Genetic Disorder
- ☐ Foster Child
- ☐ Frequent Infection
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Mental Delays
- ☐ Personality/Social
- ☐ Physical Delays
- ☐ Recurrent Headaches
- ☐ Seizure/Epilepsy
- ☐ Speech/Hearing
- ☐ Sleep Apnea/Snoring

Other: _____

_____

Child's Hobbies, Pets & Interests

_____

_____

DENTAL HISTORY

On a scale of 1-10, with 10 the highest rating:

How important is your child's dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate you child's current dental health?
1 2 3 4 5 6 7 8 9 10

Y N Has your child had any unfavorable experience with previous dental care? Please explain:

_____

_____

Y N Does your child suck a finger or pacifier?

Was your child?
- ☐ Breast Fed
- ☐ Bottle Fed

At what age was it discontinued? _____

Does your child use a "sippy cup"? Y N
If yes, what is placed in the cup: _____

Who performs brushing and flossing:
- ☐ Child
- ☐ Parent

Frequency:
Brushing: #_____ per day / week
Flossing: # _____ per day / week

Please check if your child is having problems with any of the following:
- ☐ Cavities
- ☐ Orthodontics/Crowding
- ☐ Bad breath or bad taste
- ☐ Jaw sounds or pain
- ☐ Teeth or fillings breaking
- ☐ Toothache/Pain (chewing, brushing, spontaneous, nocturnal)
- ☐ Color of teeth
- ☐ Sensitive Teeth (hot, cold, sweet)
- ☐ Bleeding, swollen or irritated gums

FLOURIDE EXPOSURE

Y N Home water supply
Y N Toothpaste
Y N Supplements (Drops/Tabs, Rinses, etc.)

Name of Previous Dentist:

_____

City: _____ State: _____

Phone Number: _____

Please share the following dates:

Your child's last cleaning _____/_____ or N/A

Your child's last oral cancer screening _____/_____

Your child's last complete X-Rays _____/_____

Why did you leave your previous dentist?

_____

_____

What is the most important thing to you about your child's future smile and dental health?

_____

_____

CONSENT FOR DENTAL TREATMENT

I request and authorized Dr. Mathias and her staff to examine, clean, and provide dental treatment on my child's teeth. I further request and authorized the taking of dental x-rays as may be considered necessary by Dr. Mathias to diagnose and/or treat my child's dental problem. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Mathias and her staff will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, as well as using a variable voice tone. I will be responsible for any charges incurred on this child for dental treatment- if another financially responsible party is declared in this agreement and they do not follow through with payment, the balance due after insurance has paid will revert back to me and become due within 30 days. I hereby authorize payment of dental insurance benefits, if any, to be made directly to Uptown Dental Clinic.

Signature _____ **Date**_____

I give my permission for the following adults to accompany my child to future dental appointments & make treatment decisions concerning my child when I am not present.

NAME/RELATIONSHIP_____

Name of financially responsible party:

_____