southoc Pediatric Dentistry & Orthodontics
Where smiles start.

Pediatric Dentistry
John De Lorme, DDS
Sam Wu, DDS
Lonnie Lovingier, DDS

Orthodontics
Chris Carter, DMD, MS

Tell Us About Your Child

Today's Date: _____ Child's Home Phone #: (_____) _____ Social Security #: _____

Child's Name: _____ Child's Birthdate: ____/____/____ Child's Age: _____
Last First MI

Nickname: _____ ❒ Male ❒ Female School: _____ Grade: _____

Child's Home Address: _____
Street City State Zip

Who may we thank for referring you? _____ Doctor Name _____ City _____

What is the primary reason for today's visit? _____

Was your child adopted? ❒ Yes ❒ No Has any member of your family been or is currently a patient in this office? ❒ Yes ❒ No

If yes, name: _____

Dental History

Is your child currently in pain? ❒ Yes ❒ No

Is this your childs first dental visit? ❒ Yes ❒ No If so, explain: _____

Has your child experienced problems with previous dental work? ❒ Yes ❒ No

Previous Dentist: _____ Date of Last Visit: _____ Date of Last X-Ray: _____

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least? _____

Have there been any injuries to your child's teeth jaws, falls, blows, chips, etc. ❒ Yes ❒ No
Does your child take fluoride vitamins or drink fluoridated water? ❒ Yes ❒ No
Has your child been seen by an orthodontist? ❒ Yes ❒ No Who? _____
Does your child brush his / her teeth daily? ❒ Yes ❒ No Does he / she require parental help? ❒ Yes ❒ No
Does your child floss his / her teeth daily? ❒ Yes ❒ No Does he / she require parental help? ❒ Yes ❒ No

Name of Parent's dentist: _____ City: _____ Phone: (_____) _____

Does / Did your child have any of the following habits? (please circle)

❒Yes ❒No Lip Sucking and Nail Biting	❒Yes ❒No Clenching / Grinding Teeth	❒Yes ❒No Tongue / Cheek Biting	❒Yes ❒No Mouth Breather
❒Yes ❒No Chewing on Objects	❒Yes ❒No Thumb / Finger Sucking	❒Yes ❒No Used Pacifier	❒Yes ❒No Speech Problems
❒Yes ❒No TMJ / TMD Pain	❒Yes ❒No Nursing Bottle Habits	❒Yes ❒No Tongue Thrust	❒Yes ❒No Breast Fed

Medical History

Child's Physician: _____ Phone: (_____) _____ Date of last visit: _____

Address: _____

Is your child currently under the care of a physician? ❒ Yes ❒ No Please explain: _____

Does your child have social/personality/temperament concerns that we should be aware of? _____

Please describe your child's current physical health: ❒ Good ❒ Fair ❒ Poor **Are Immunizations Current?** ❒ Yes ❒ No

Please list all medicatons and dosage that your child is currently taking: _____

Please list all drugs and / or things that cause your child allergic reactions: _____

Anything you would like to discuss with the Doctor in Private? ❒ Yes ❒ No

Has your child had / experienced any of the following: (please circle)

Abnormal Bleeding	❒Y ❒N	Chicken Pox	❒Y ❒N	Heart Murmur	❒Y ❒N	Mononucleosis	❒Y ❒N
AIDS / HIV+	❒Y ❒N	Congenital Birth Defect	❒Y ❒N	Hemophilia	❒Y ❒N	Recurrent Headaches / Frequency	❒Y ❒N
Allergies	❒Y ❒N	Congenital Heart Defect	❒Y ❒N	Hepatitis	❒Y ❒N	Rheumatic Fever	❒Y ❒N
Anemia	❒Y ❒N	Diabetes	❒Y ❒N	High Blood Pressure	❒Y ❒N	Seizures	❒Y ❒N
Any Hospital Stays	❒Y ❒N	Endocrine System Disorders	❒Y ❒N	Hives	❒Y ❒N	Scarlet Fever	❒Y ❒N
Any Operations	❒Y ❒N	Epilepsy	❒Y ❒N	Kidney Problems	❒Y ❒N	Sickle Cell Anemia	❒Y ❒N
Asthma	❒Y ❒N	Frequent Infections	❒Y ❒N	Liver / GI System Problems	❒Y ❒N	Sight Disorders	❒Y ❒N
Blood Dyscrasis	❒Y ❒N	Handicaps	❒Y ❒N	Low Blood Pressure	❒Y ❒N	Significant Injuries / What	❒Y ❒N
Blood Transfusion/Date	❒Y ❒N	Behavior / Learning / Disabilities	❒Y ❒N	Lupus	❒Y ❒N	Skin Rash	❒Y ❒N
Breathing / Lung Problems	❒Y ❒N	Mentally / Physically Disabled	❒Y ❒N	Measles	❒Y ❒N	Tonsilitis	❒Y ❒N
Cancer / Tumors	❒Y ❒N	Hearing Impaired	❒Y ❒N	Mitral Valve Prolapse	❒Y ❒N	Tuberculosis (TB)	❒Y ❒N

Please discuss any serious medical problems your child experiences(ed): _____

Parents Information

Parent's Marital Status: ❒ Married ❒ Divorced ❒ Separated ❒ Widowed ❒ Remarried ❒ Single Family's E- Mail: _____

Parent #1 Birthdate: ____ /____ /____ Home Phone #: (_____) _____ Work Phone #: (_____) _____

Name: _____ Social Security #: _____ Drivers License #: _____

Address: _____
Street City State Zip

Employer: _____ Occupation: _____ Length of Employment: _____

Employers Address: _____
Street City State Zip

Parent #1 Cell # (_____) _____ Parent#2 Cell #: (_____) _____

Parent #2 Birthdate: ____ /____ /____ Home Phone #: (_____) _____ Work Phone #: (_____) _____

Name: _____ Social Security #: _____ Drivers License #: _____

Address: _____
Street City State Zip

Employer: _____ Occupation: _____ Length of Employment: _____

Employers Address: _____
Street City State Zip

Name of parent who resides with the child: _____

Nearest relative: _____ Address: _____ Phone: _____

Is your child covered by a dental insurance plan? ❒ Yes ❒ No

Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone #: (_____) _____ Group # (Plan, Local, or Policy#): _____

Insurance Co. Address: _____
PO Box / Street City State Zip

Insured's Name: _____ Relationship to Patient: _____

Insured's Address (if different from above): _____ Home Phone #: (_____) _____

Insured's Birthdate: ____ /____ /____ Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone #: (_____) _____ Group # (Plan, Local, or Policy#): _____

Insurance Co. Address: _____
PO Box / Street City State Zip

Insured's Name: _____ Relationship to Patient: _____

Insured's Address (if different from above): _____ Home Phone #: (_____) _____

Insured's Birthdate: ____ /____ /____ Social Security #: _____ Insured's Employer: _____

Financial Responsibility

I assume financial responsibility for all dental treatment and medications provided for my child, and understand that payment is expected on the date services are provided. I request and authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered on my behalf or my dependents.

_____
Signature Date

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors and / or their health practitioners.

I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and healthcare operations.

_____
Signature Date

Medical history review: ____ /____