CYPRESS
Pediatric Dentistry
Kacie Shelton, DDS, MSD

CHILD'S NAME: _____ SEX: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

NAME OF SCHOOL: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

BIRTHDATE: _____

PREFERRED CONTACT NUMBER:

_____

EMAIL: _____

RESPONSIBLE PARTY

PARENTS NAME: _____

RELATIONSHIP TO CHILD: _____

DATE OF BIRTH: _____

EMPLOYER: _____ OCCUPATION: _____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

PARENTS NAME: _____

RELATIONSHIP TO CHILD: _____

DATE OF BIRTH: _____

EMPLOYER: _____ OCCUPATION: _____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

CIRCLE APPROPRIATE SELECTION:

SINGLE MARRIED DIVORCED WIDOWED SEPERATED

INSURANCE INFORMATION

PRIMARY SUBSCRIBER: _____

INSURANCE COMPANY: _____

SUBSCRIBER ID #:_____SS #:_____

GROUP NUMBER: _____

RELATIONSHIP TO PATIENT: _____

INSURANCE PHONE NUMBER:

_____

ADDITIONAL INSURANCE

NAME OF INSURED: _____

INSURANCE COMPANY: _____

SUBSCRIBER ID #:_____SS #: _____

GROUP NUMBER: _____

RELATIONSHIP TO PATIENT: _____

INSURANCE PHONE NUMBER:

_____

SURGICAL HISTORY, MEDICATIONS, ALLERGIES

PHYSICIAN NAME: _____

PHYSICIAN PHONE: _____

DATE OF LAST EXAM: _____

HAS YOUR CHILD EVER BEEN HOSPITALIZED?	**YES**	**NO**
HAS YOUR CHILD EVER HAD SURGERY?	**YES**	**NO**
DOES YOUR CHILD TAKE ANY MEDICATIONS? (INCLUDING OVER THE COUNTER)	**YES**	**NO**
DOES YOUR CHILD HAVE ANY ALLERGIES?	**YES**	**NO**
HAS YOUR CHILD EVER HAD AN ALLERGIC REACTION TO ANESTHESIA?	**YES**	**NO**
DOES YOUR CHILD REQUIRE ANTIBIOTICS PRIOR TO DENTAL TREATMENT?	**YES**	**NO**

EXPLAIN ANY ANSWERS MARKED YES:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY

AUTISM	**YES**	**NO**	**HEARING DISORDER**	**YES**	**NO**
ADD/ADHD	**YES**	**NO**	**HEART DISEASE**	**YES**	**NO**
AUTOIMMUNE DISEASE	**YES**	**NO**	**HEART MURMUR**	**YES**	**NO**
BLEEDING DISORDER	**YES**	**NO**	**HEPATITIS**	**YES**	**NO**
DIABETES	**YES**	**NO**	**HIV/AIDS**	**YES**	**NO**
ECZEMA	**YES**	**NO**	**IMMUNE DISEASE**	**YES**	**NO**
EPILEPSY	**YES**	**NO**	**KIDNEY DISEASE**	**YES**	**NO**
EYE DISORDER	**YES**	**NO**	**LIVER DISEASE**	**YES**	**NO**
GENETIC DISEASE	**YES**	**NO**	**MALIGNANCY/NEOPLASM**	**YES**	**NO**
GI DISEASE	**YES**	**NO**	**NON-VERBAL**	**YES**	**NO**

EXPLAIN ANY ANSWERS MARKED YES OR ANY LIST ANY CONDITION NOT LISTED:

_____
_____
_____

PLEAE LIST THE NAME AND PHONE NUMBER FOR ANY SPECIALIST THAT YOUR CHILD IS FOLLOWED BY:

_____
_____
_____

DENTAL HISTORY

IS YOUR CHILD CURRENTLY EXPERIENCING DENTAL PAIN?	**YES**	**NO**
DOES YOUR CHILD HAVE A HISTORY OF DENTAL PAIN?	**YES**	**NO**
HAS YOUR CHILD EVER SUFFERED TRAUMA TO THEIR FACE?	**YES**	**NO**
DO YOU HAVE ISSUES WITH PREVIOUS DENTAL WORK?	**YES**	**NO**
HISTORY OF BAD DENTAL EXPERIENCE? (PLEASE EXPLAIN	**YES**	**NO**

REASON FOR TODAYS VISIT?

_____
_____
_____
_____
_____
_____
_____
_____
_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

_____ _____

LEGAL GUARDIAN'S SIGNATURE DATE

_____

PRINT NAME