WELCOME

Children's Dentistry of Pocatello

425 E. Alameda Rd. Pocatello, ID 83201 Phone: (208)238-1165

Patient's First Name: _____ Patient's Last Name: _____

Preferred Name (If Different): _____ Date of Birth: _____

Gender: _____ Male _____ Female School: _____ Grade: _____

Mailing Address: _____

Street City State Zip Code

Home Phone: _____ Cell: _____ Work: _____

E-mail Address: _____

Primary Responsible Party Marital Status: _____Married _____Divorced _____Widowed _____Single _____Other

First Name: _____ Last Name: _____ Date of Birth: _____

Social Security Number ***(Required)***: _____ Driver's License #: _____

Mailing Address: _____

Street City State Zip Code

Home Phone: _____Cell: _____Work: _____

Employer: _____ Length of Employment: _____

Secondary Responsible Party Marital Status: _____Married _____Divorced _____Widowed _____Single _____Other

First Name: _____ Last Name: _____ Date of Birth: _____

Social Security Number ***(Required)***: _____ Driver's License #: _____

Mailing Address: _____

Street City State Zip Code

Home Phone: _____Cell: _____Work: _____

Employer: _____ Length of Employment: _____

Primary Dental Insurance Name

of Insurance Company: _____ Insurance Phone #: _____

Insurance Address: _____

Street City State Zip Code

Subscriber Name: _____ Relation to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's Employer: _____

Policy Number: _____ Group Number: _____

Secondary Dental Insurance ***(If Applicable)***

Name of Insurance Company: _____ Insurance Phone #: _____

Insurance Address: _____

Street City State Zip Code

Subscriber Name: _____ Relation to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's Employer: _____

Policy Number: _____ Group Number: _____

PO Box/Street City State Zip

Dental & Medical History

Is the child currently in pain? ☐ Yes ☐ No Reason for today's visit? _____
Has child been previously treated for dental decay? ☐ Yes ☐ No
Does child brush his/her teeth daily? ☐ Yes ☐ No Previous/Present Dentist? _____
Does child floss daily? ☐ Yes ☐ No
Does either parent have history of dental carries? ☐ Yes ☐ No
Does child have siblings with history of dental carries? ☐ Yes ☐ No

What type of toothpaste does child use? _____

Does/did the child have any of the following habits?

☐ Lip sucking/biting	☐ Clenching/Grinding teeth	☐ Tongue/Cheek biting	☐ Mouth Breather
☐ Nail biting	☐ Thumb/finger sucking	☐ Used pacifier	☐ Speech problems
☐ Chewing on objects	☐ Nursing bottle habits	☐ Tongue thrust	☐ Breast fed
☐ Sleep with bottle	☐ Drink pop regularly	☐ Drink juice regularly	

Did mother have any complications during pregnancy? Please explain: _____

Did mother take any medications during pregnancy? Please explain: _____

When was the child weaned from a bottle? _____

Was the child ill during infancy? Please explain: _____

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

Please list all the drugs the child is currently taking: _____

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

Address: _____
Street City State Zip

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor Are Immunizations current? ☐ Yes ☐ No

Besides the following, please list all drugs and/or things that cause the child allergic reactions:

Latex? ☐ Yes ☐ No Metals? ☐ Yes ☐ No Plastic? ☐ Yes ☐ No Penicillin? ☐ Yes ☐ No Tetracycline? ☐ Yes ☐ No

_____

_____

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Has the child had/experienced any of the following:

☐ Abnormal bleeding	☐ Chicken Pox	☐ Heart Murmur-innocent	☐ Mitral Valve Prolapse
☐ ADHD	☐ Cleft Lip/Palate	☐ Heart Murmur-premed	☐ Mononucleosis
☐ AIDS/HIV+	☐ Congenital Heart Defect	☐ Hemophilia	☐ Psychiatric Problems
☐ Allergies	☐ Convulsions	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Scarlet Fever
☐ Any Hospital Stay/Op.	☐ Down Syndrome	☐ Hives	☐ Seizures
☐ Asthma	☐ Epilepsy	☐ Kidney Problems	☐ Sickle Cell Anemia
☐ Autism	☐ Frequent Headaches	☐ Liver Problems	☐ Skin Rash
☐ Blood Transfusion	☐ Handicaps/Disabilities	☐ Low Blood Pressure	☐ Tonsilitis
☐ Cancer	☐ Hearing Impairment	☐ Lupus	☐ Tuberculosis (TB)
☐ Cerebral Palsy	☐ Measles		

Please discuss any serious medical problems the child experiences/ed: _____

_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Hugues and the dental team to examine, clean and provide dental treatment on my child's teeth. I further authorize the taking of dental x-rays as may be considered necessary by Dr. Hugues to diagnose and/or treat my child's dental problem. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

_____ _____
Signature Date