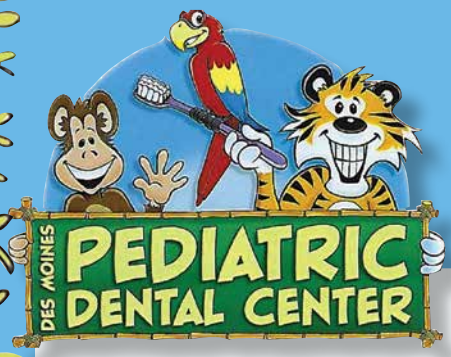

4949 Westown Pkwy., Suite 150
West Des Moines, IA 50266-6716
(515) 225-0066

tell us about your child

Today's Date:_____ Child's Home Phone #: _____

Child's Name:_____ Nickname: _____
Last First MI

Social Security #:_____ Child's Birthdate: _____ Child's Age: ___ ❑ Male ❑ Female

Child's Home Address: _____
Street City State Zip

Whom may we thank for referring you?_____

Emergency Contact Name: _____ Phone #: _____ Relationship #: _____

parent information

Parent's Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Single ❑ Partnered

Parent: ❑ Mother ❑ Father ❑ Step Parent ❑ Guardian Does this person have custody of this child? ❑ Yes ❑ No

Please list anyone else who has custody of this child and/or any other custody arrangements that we should be aware of:_____

Name: _____ Social Security #: _____

Birthdate:_____ Home Phone #:_____ Work Phone #:_____

Email Address:_____ Cell Phone #:_____

Address: _____
Street City State Zip

Employer: _____ Occupation: _____

Parent: ❑ Father ❑ Mother ❑ Step Parent ❑ Guardian Does this person have custody of this child? ❑ Yes ❑ No

Name: _____ Social Security #: _____

Birthdate:_____ Home Phone #:_____ Work Phone #:_____

Email Address: _____ Cell Phone #:_____

Address: _____
Street City State Zip

Employer: _____ Occupation: _____

insurance information

Primary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

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 Birthdate: _____ Social Security #: _____

Insured's Employer: _____

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

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 Birthdate:_____ Social Security #: _____

Insured's Employer:_____

continued on back

dental history

Is the child currently in pain? ☐ Yes ☐ No What is the primary reason for today's visit? _____

Has the child experienced problems with previous dental work? ☐ Yes ☐ No

Does the child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Previous / Present Dentist: _____ Date of last visit: _____

Please Circle

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

medical history

Child's Physician: _____ Phone #: _____ Date of last visit: _____

Address: _____

Street City State Zip

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

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Are the child's immunizations current? ☐ Yes ☐ No

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

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

Latex? ☐ Yes ☐ No Metals/Nickel? ☐ Yes ☐ No Plastic? ☐ Yes ☐ No Penicillin? ☐ Yes ☐ No

Tetracycline? ☐ Yes ☐ No Other? ☐ 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 – requires antibiotic	☐ Mononucleosis
☐ ADHD	☐ Cleft Lip/Palate	☐ Hemophilia	☐ Psychiatric Problems
☐ AIDS/HIV+	☐ Congenital Heart Defect	☐ Hepatitis	☐ Rheumatic Fever
☐ Allergies	☐ Convulsions	☐ High Blood Pressure	☐ Scarlet Fever
☐ Anemia	☐ Diabetes	☐ Hives	☐ Seizures
☐ Any Hospital Stay/Operations	☐ Down Syndrome	☐ Kidney Problems	☐ Shunts
☐ Asthma	☐ Epilepsy	☐ Liver Problems	☐ Sickle Cell Anemia
☐ Autism Spectrum Disorder	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Skin Rash
☐ Blood Transfusion	☐ Handicaps/Disabilities	☐ Lupus	☐ Tonsillitis
☐ Cancer	☐ Hearing Impairment	☐ Measles	☐ Tuberculosis (TB)
☐ Cerebral Palsy	☐ Heart Murmur – Innocent	☐ Mitral Valve Prolapse	☐ Other

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 that it is my responsibility to inform this office of any changes in my child's medical status. I authorize Des Moines Pediatric Dental Center 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 the Doctor 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 _____