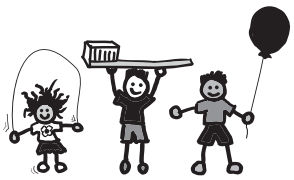

Great Beginnings

Pediatric & Orthodontic Dental Specialists

WELCOME

William L. Chambers, DDS, MS, PA, Diplomate • Angela P. Baechtold, DDS, MS, Diplomate
Ryan J. Haldeman, DDS, MS, PA • Douglas B. Pratt, DDS, PA, Diplomate
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GreatBeginningsPedo.com • Appts@GreatBeginningsPedo.com

Patient Information

Date _____

Patient's Name _____ Nickname _____ Sex _____
First Middle Last

Physical Address _____

Date of Birth _____ Age _____ Weight _____ Child lives with: ❑ Both parents ❑ Mother ❑ Father ❑ Other

Names of brothers or sisters in practice _____ School Name _____

Patient's Physician or Pediatrician Name _____ Family Dentist _____

Whom may we thank for referring you? _____

Responsible Party Information

❑ Guardian ❑ Widowed
❑ Single ❑ Separated
❑ Married ❑ Divorced

Name _____ Marital Status:
First Middle Last

Physical Address _____
Street/P.O. Box City State Zip

Mailing Address *(if different than above)* _____
Street/P.O. Box City State Zip

❑ Own ❑ Rent How long at this address _____ Preferred Phone Number _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security Number _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed _____
(If self-employed, list name of business)

Spouse/(Other) _____ Relationship to Patient _____
First Middle Last

Spouse's/(Other's) Address (if different) _____
Street City State Zip

Spouse's/(Other's) Employer _____ Occupation _____ No. Years Employed _____
(If self-employed, list name of business)

Spouse's/(Other's) Social Security Number _____ Birthdate _____ Preferred Phone _____

Spouse's/(Other's) Email Address _____ Work Phone _____

Dental Insurance Information

Policy Holder's Name _____ Insured's Soc Sec. # _____ Birthdate ____/____/____

Insurance Co. _____ Group No. _____ Subscriber No. _____

Insurance Co. Address _____ Phone No. _____

Policy Holder's Employer _____ Do you have other dental insurance? ❑ Yes ❑ No

Emergency Information

Name of nearest emergency contact not living with you _____ Phone No. _____

Address _____ Relationship to Patient _____
Street City State Zip

I understand that where appropriate, credit bureau reports may be obtained.

Parent or Guardian Signature _____ Date _____

MEDICAL HISTORY

Has your child ever had any of the following medical problems?

Y N	Allergies/Asthma	Y N	Convulsion/Epilepsy	Y N	Hyperactive
Y N	Anemia	Y N	Developmental Delay	Y N	Lung Problems
Y N	Austism Spectrum	Y N	Diabetes	Y N	Mental Disorder
Y N	Attention Deficit Disorder	Y N	Drug/Alcohol Abuse	Y N	Nervous System Disorder
Y N	Bleeding Disorder/Hemophilia	Y N	Fainting	Y N	Rheumatic Fever
Y N	Bronchitis	Y N	Handicap/Disabilities	Y N	Shunt
Y N	Cancer/Chemotherapy	Y N	Hearing Impairment	Y N	Speech Disorder
Y N	Cerebral Palsy	Y N	Hepatitis	Y N	Tuberculosis
Y N	Congenital Heart Defect	Y N	HIV/AIDS	Y N	Tumors/Growths

Is your child ❑ delayed ❑ normal ❑ advanced in the learning process?

Has your child experienced any other physical or mental disorder that is not listed above? Yes ❑ No ❑

If yes, please describe:_____

Has any immediate family member had any of the above? Yes ❑ No ❑ If Yes, please describe:_____

_____

Is your child allergic to any of the following drugs:

Y N Penicillin Y N Amoxicillin Y N Erythromycin Y N Codeine Y N Dental Anesthetic

Is your child allergic to any other drugs? Yes ❑ No ❑ If Yes, please list: _____

Is your child allergic to Latex, red dye or anything we need to be aware of? Yes ❑ No ❑ If Yes, please list: _____

_____

Is your child presently under the care of a physician for any illness? Yes ❑ No ❑ If Yes, please list: _____

_____

List any drugs or medicines presently being taken:_____

Has your child ever been hospitalized? Yes ❑ No ❑ If Yes, please give reason and date(s)_____

_____

DENTAL HISTORY

Do you want complete treatment for your child? Yes ❑ No ❑

Why did you bring your child to see us today? _____

Is this your child's first visit to the dentist? Yes ❑ No ❑ Name of previous dentist: _____

Has your child ever had a serious/difficult problem associated with previous dental work? Yes ❑ No ❑ If Yes, please explain: _____

_____

Date of last dental visit_____ For what service_____

Were any x-rays taken? Yes ❑ No ❑ If Yes, have x-rays been sent to our office? _____

How do you expect your child to behave in our office? _____

Yes	No	
____	____	Does your child brush his/her teeth daily?
____	____	Do you assist child with tooth brushing?
____	____	Is dental floss used? If so, how often?_____
____	____	Is fluoride taken in any form? How — Vitamins: Yes ❑ No ❑ Toothpaste: Yes ❑ No ❑ Drinking Water: Yes ❑ No ❑
____	____	Any mouth habits (thumbsucking, nail biting, mouth breather, nursing bottle habits, pacifier, etc.)
____	____	Any injuries to mouth, teeth, head? Date(s) _____
____	____	Has child ever had jaw joint pain or tenderness?

May we request release of your child's medical records? Yes ❑ No ❑

Thank you for your help. If there is any information that you feel might be of value to us during your treatment of your child, please add it here:

_____

I give my consent to needed dental treatment and the use of proper and acceptable methods to complete said treatment for my child, (child's full name) _____. I accept responsibility for payment of services rendered.

Signed (parent or guardian): _____ Date: _____

OFFICE USE ONLY: Doctor's Comments: _____

_____