Bunker Hill Pediatric Dentistry, PLLC
Welcome To Our Practice!!

We want to welcome your child into our practice. Our goal is to make his/her dental experience pleasant and educational. Please provide us with all information requested so that we can better understand and care for your child.

Date: _____

Patient Name: _____Nickname: _____Sex: _____
Last First MI
Birthday: _____ Age: _____ SSN:_____
Siblings & Ages _____
_____
Home Phone:(____)_____ School: _____ Grade: _____ Weight: _____
Child's Address:_____
Street Apt No.
_____
City State Zip
Reason for visit:_____

Health Information
Has your child ever had difficulty with any of the following: (Please check all that apply)

___ ADHD	___Cerebral Palsy	___ Kidney Disorder	___ Rheumatic Fever
___ AIDS/HIV	___Chicken Pox	___Liver Disorder	___Sinus Problems
___Anemia	___Convulsions	___Lung Disease	___Thyroid Disorders
___Asthma	___Diabetes	___ Measles/Mumps	___Tuberculosis
___Bladder Disease	___Epilepsy	___ Mental Retardation	___Vision Disorders
___Blood Transfusions	___Hearing Disorders	___ Mononucleosis	___Behavioral Problems
___Bleeding Disorders	___Heart Condition	___Pregnancy	___Emotional Problems
___Cancer	___Hepatitis	___Respiratory Problems	___Other

Please describe all above conditions that apply:
_____
_____

	Yes	No
Is your child in good health?	____	____
Are immunizations up-to-date?	____	____
Is your child taking any medicines or drugs:	____	____
Has your child ever been hospitalized or had surgery?	____	____
Does your child have a heart murmur or condition requiring Prophylactic Antibiotic coverage before dental treatment	____	____
Does your child have any allergies (drugs or latex)	____	____

If yes, please specify:_____

Child's Pediatrician _____ Last Visit:_____ Phone: _____
Has your child been seen by another dentist?_____ If yes, name:_____
Date of last visit:_____ Phone: _____ X-rays: _____
Has your child ever had an unfavorable dental experience?_____
How often does your child brush (i.e. once per day, twice per day): _____
Who is responsible for teeth cleaning? ___Child ___Parent ___Both
Was your child breast fed? _____ Bottle fed?_____ Age discontinued? _____
Does your child: (Please check all that apply)
___Suck thumb/Finger ___Suck/Bite lips ___Grind teeth ___Pacifier
___Bite/Chew nails ___Chew hard objects ___Clench jaw
What is your home water source?___Public system___ Private well___Other _____

Because your child is a minor, it is necessary that signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment is performed. The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate there to. This consent shall remain in full force and effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment should named responsible party fail or insurance benefits be denied.

Signature of Parent of Guardian:_____ Date:_____

Office Use
I verbally reviewed the medical/dental information above with the parent/guardian regarding the patient named herein. Initials ____ Date _____

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Who is Accompanying the Child today?

Name:_____ Relationship:_____
Do you have legal custody of this child?_____ Is your child adopted?_____
Child lives with: ___Both parents ____Mom ____Dad ____Grandparent ____Guardian

I have listed below two persons who might be involved in his/her dental updates and/or transportation.
1. _____ 2. _____

Parent (or Guardian) Information

Father's Name: _____
DOB: _____
Soc. Sec. #_____
Home address if different from child:
_____
_____
Home #: _____
Work #: _____
Cell/Pager #:_____
Email:_____
Employer:_____
Occupation:_____
Marital Status: ___Single ___Married
___Divorced ___Widowed

Mother's Name: _____
DOB:_____
Soc. Sec. #_____
Home address if different from child:
_____
_____
Home #: _____
Work #:_____
Cell/Pager #:_____
Email:_____
Employer:_____
Occupation:_____
Marital Status: ___Single ___Married
___Divorced ___Widowed

Emergency Information

Name_____ Relationship_____ Phone_____

Person Responsible for Account

Name:_____ Relationship:_____
Billing address_____
Home phone _____ Work _____ Cell _____
DL#_____ SS#_____

Primary Insurance Information

Name of Insured:_____
Insured Date of Birth:_____ ID No._____Group No._____
Insured's address_____
Insured's Employer Name_____
Employer address_____
Patients relationship to insured: ___self ___Spouse ___Child ___ Other_____
Insurance plan name_____ phone _____
Insurance plan address_____

Referral Information – who can we thank for referring you to our office?

___another patient ___dental office ___ pediatrician ___ yellow pages ___website ___newspaper ___school ___work
___other_____ Name of office referring you to our practice _____

I authorize the dentist to release any information to third party payers and /or other health practitioners, if necessary. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me.

Signed: _____ Date: _____

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