Get- Acquainted Questionnaire

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Today's Date_____

Child's Name_____

Preferred Name_____Age_____ Date of Birth_____ Sex: ❑Male ❑Female

SS#_____ Attends what school_____ Grade_____

Names and ages of brothers and sisters_____

Father_____ SS#_____

Date of Birth_____ Home phone_____ Cell Phone_____ Preferred: ❑Home ❑Cell

Residence_____ City_____ State_____ Zip_____

Employed by_____ Business Phone_____

Employer address_____

Mother_____ SS#_____

Date of Birth_____ Home phone_____ Cell Phone_____ Preferred: ❑Home ❑Cell

Residence_____ City_____ State_____ Zip_____

Employed by_____ Business Phone_____

Employer address_____

Parents are: ❑Married ❑Single ❑Divorced - Child lives with: _____

Email Address of ❑Mother or ❑Father :_____

Who is responsible for making appointments? Name_____

*Please provide a friend or relative who can be contacted in case of emergency.

Emergency Contact_____ Phone_____

How did you hear about us? ❑ Insurance_____ ❑ Family / Friend _____

❑ Physician/Dentist_____ ❑ Website ❑ Post Card ❑ Fitness Club ❑ Drive by

❑ Other_____

We will be glad to process any insurance claim forms. However, a payment may be due at the time of service. Our office requires one of the following arrangements for payment of fee at time of service. Please check your preference: ❑Cash ❑Personal check ❑Visa/Mastercard/Discover ❑Care Credit ❑Currently covered by Medicaid

Primary Dental Insurance *Please present card*

Insurance Co. Name: _____ Group #(Plan, Local or policy #)_____

Policyholder's name: _____ Relationship to patient: _____

Policyholder's Date of Birth: _____ Policyholder's SS#_____

Policyholder's Employer: _____ If using Secondary Insurance, please show your card.

Policyholder SSN and DOB are required if you would like our office to submit your insurance.

I authorize the release of any information regarding this claim. I acknowledge that Southwest Pediatric Dentistry has presented and made available to me their "Notice of Privacy Practices" for protected health information (available on website or upon request). I authorize Southwest Pediatric Dentistry to use and disclose my Protected Health Information for treatment, payment and healthcare operations.

Signature_____ **Date** _____

As a courtesy, we will complete your insurance claim forms at our cost. A written cost estimate is always given to you before the service is provided. 25% of all non-routine dental visits will be required at time of service. If your insurance fails to pay our office within 60 days, then you will be responsible for the balance. There will be a 16% per annum interest rate charged on accounts that are 30 days or more past due. ***Thank you.***

Child Health/Dental History Questions

Has the child had any history of, or conditions related to, any of the following (if not listed, please explain):

❑ Anemia	❑ Cancer	❑ Growth Problems	❑ Liver Disease	❑ Psychiatric Treatment
❑ Asthma	❑ Cerebral Palsy	❑ Hearing Impairment	❑ Lung Disease	❑ Recurrent Headaches
❑ Attention Deficit	❑ Cleft Lip/Palate	❑ Heart /Heart Defect	❑ Mental Retardation	❑ Rheumatic fever
❑ Autism	❑ Diabetes	❑ Hemophilia	❑ MRSA	❑ Seizures
❑ Bladder/Kidney	❑ Eye Disorders	❑ Hepatitis	❑ Muscle Disorders	❑ Sickle Cell Anemia
❑ Bleeding Disorders	❑ Eating Disorder	❑ HIV +/AIDS	❑ Nose/Throat Disease	❑ Thyroid Disease
❑ Bones/Joints	❑ Fainting	❑ Latex Allergy	❑ Pregnancy (teen)	❑ Tuberculosis

Please explain:_____

_____

Please list the name and phone number of the child's physician:

Name of Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

What is the greatest concern you have regarding your child's teeth?_____

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... 1. If yes, please list:_____	❑	❑
2. Is the child allergic to anything? i.e. medications, latex or food? ..... 2. If yes, please explain:_____	❑	❑
3. Has the child ever had a serious illness? If yes, when_____ Please describe_____ 3.	❑	❑
4. Is the child currently being treated for any illness? ..... 4.	❑	❑
5. Has the child ever been hospitalized? ..... 5.	❑	❑
6. Has the child ever had a complication to general anesthetic? ..... 6.	❑	❑
7. Does the child have any speech difficulties? ..... 7.	❑	❑
8. Has the child ever had a blood transfusion? ..... 8.	❑	❑
9. Is the child physically, mentally , or emotionally impaired? ..... 9.	❑	❑
10. Does the child experience excessive bleeding when cut? ..... 10.	❑	❑
11. Is this the child's first visit to the dentist? If not the first visit, when was the last dental visit?_____ 11.	❑	❑
12. Has the child ever had any negative dental or medical experiences? ..... 12.	❑	❑
13. Has the child ever had any dental radiographs (x-rays) taken? ..... 13.	❑	❑
14. Has the child ever suffered any injuries to the mouth, head or teeth? ..... 14.	❑	❑
15. What type of water does your child drink? ❑ City Water ❑ Well Water ❑ Bottled Water ❑ Filtered Water		
16. Does the child take fluoride supplements? ..... 16.	❑	❑
17. Is fluoride toothpaste used? ..... 17.	❑	❑
18. How many times are the child's teeth brushed each day?_____ When are the teeth brushed?_____		
19. Has either parent had a lot of tooth decay? ..... 19.	❑	❑
20. Has the child had a recent toothache? ..... 20.	❑	❑
21. Does the child suck his/her thumb or fingers, or use a pacifier? ..... 21.	❑	❑
22. At what age did the child stop bottle feeding?_____ Breast Feeding? Age_____		
23. Does the child ever fall asleep with a bottle or sippy cup? ..... 23.	❑	❑
24. Does the child participate in sports? If yes, please list:_____ 24.	❑	❑

As a minor child, it is necessary that signed permission be obtained from a parent or guardian before any dental care can begin. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete treatment, including diagnostic radiographs. Protective restraints are used only when children may harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. If my child ever has a change in his/her health, I will inform the doctor at the next appointment without fail. I will be responsible for the cost of this dental treatment. For specific procedures, further information will be provided.

Signature_____ **Relation to child**_____ **Date**_____