Welcome

CHILDREN 13 AND UNDER

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely.

PERSONAL INFORMATION

Child's Full Name:____ Date: ____________
FIRST MIDDLE LAST

SS#:______________________ DOB:______________ Age:________ Sex:________ Race: __________

Nickname:______________________School:______________________________ Grade:________

Hobbies: ____

Child's Physician:______________________________ Phone #:____________________

Father's Name:______________________SS#:__________________DOB: __________

Mother's Name:______________________SS#:__________________DOB: __________

Home Address:____
STREET CITY STATE ZIP

Person responsible for payment of account: ______________________________________

Name of your last Dentist:______________________ Dentist's Phone #:____________________

PRIMARY INSURANCE

Insurance Company: ____

Mailing address: ____
STREET CITY STATE ZIP

Policy #:______________________ Grp #:__________ Insurance Phone #: ________________

Insured's Name:____________________ SS#:______________________ DOB: __________

Insured's Employer:______________________________ Employer's Phone #:______________

SECONDARY INSURANCE (if applicable)

Insurance Company: ____

Mailing address: ____
STREET CITY STATE ZIP

Policy #:______________________ Grp #:__________ Insurance Phone #: ________________

Insured's Name:____________________ SS#:______________________ DOB: __________

Insured's Employer:______________________________ Employer's Phone #:______________

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INITIALS

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company.

BECAUSE WE LIKE TO THANK OUR REFERRALS WITH A GIFT, PLEASE SHARE WITH US THE PATIENT'S NAME: ______________________________

YOUR MEDICAL HISTORY

REASON FOR THIS VISIT:______________________________

Has any member of your family been a patient at our office? ❒ YES ❒ NO

Is your child under a physician's care at this time? ❒ YES ❒ NO

Explain:______________________________ Date of last physical exam: ______________

Child's general health condition:______________________________

Is your child currently taking any medications, drugs, or pills? Please list below.

____

Is your child mentally or physically handicapped? ❒ YES ❒ NO

Has your child had any surgery, oxygen therapy or general anesthetic? ❒ YES ❒ NO

Has your child had any history of sore throats, tonsilitis, or earaches? ❒ YES ❒ NO

Is your child allergic to any food? ❒ YES ❒ NO List: ______________

Is your child allergic to any medicines? ❒ YES ❒ NO List: ______________

Is your child allergic to penicillin? ❒ YES ❒ NO

List all known allergies:______________________________

Has your child ever received antibiotics? ❒ YES ❒ NO What:______________

When (age):______________ How long?______________

Has your child had unpleasant dental or medical experiences? ❒ YES ❒ NO Explain: ______________

Date of last dental care:______________ Has your child ever had any reaction to dental anesthetic? ❒ YES ❒ NO

Has your child ever had excessive bleeding after a cut or tooth removal? ❒ YES ❒ NO

Has your child ever had flouridated tap water? ❒ YES ❒ NO How long? ______________

Has your child ever had flouride solutions applied by a dentist? ❒ YES ❒ NO How often? ______________

Are flouride tablets or vitamins prescribed by your dentist or physician? ❒ YES ❒ NO

Explain: ______________________________

HAS YOUR CHILD EVER BEEN INFORMED THAT THEY NEED TO BE PRE-MEDICATED BEFORE DENTAL PROCEDURES? ❒ YES ❒ NO

Has your child had:

Condition			Condition			Condition		
Measles	❒ YES	❒ NO	Heart Trouble	❒ YES	❒ NO	Epilepsy – Conv.	❒ YES	❒ NO
Mumps	❒ YES	❒ NO	Rheumatic Fever	❒ YES	❒ NO	Diabetes	❒ YES	❒ NO
Chicken Pox	❒ YES	❒ NO	Excessive Bleeding	❒ YES	❒ NO	Anemia	❒ YES	❒ NO
Whooping Cough	❒ YES	❒ NO	Blood Pressure (H / L)	❒ YES	❒ NO	X-Ray Therapy	❒ YES	❒ NO
Scarlet Fever	❒ YES	❒ NO	Liver Disease	❒ YES	❒ NO	Asthma	❒ YES	❒ NO
Diphtheria	❒ YES	❒ NO	Kidney Disease	❒ YES	❒ NO	Tuberculosis	❒ YES	❒ NO
			Lung Disease	❒ YES	❒ NO	Mouth Injuries	❒ YES	❒ NO
			Mitral Valve Prolapse	❒ YES	❒ NO	Latex Allergy	❒ YES	❒ NO

AUTHORITY TO TREAT

I hereby authorize Dr. Randomski to treat the above mentioned patient using restorative and patient management techniques that are acceptable and proper. I understand that the treatment plan to be presented, as well as the fees outlined, could change depending upon the time elapsed since the intial examination and the extent of decay.

To the best of my knowledge, all the above answers are correct. If there are any changes in my child's medical health, I will inform the dentist before my child's next appointment or before any treatment is started. I have read and agree to all the terms outlined on this form. ***PERSON SIGNING MUST BE 18 YEARS OR OLDER.***

Parent/Guardian: ______________________________ Date: ______________

Print Name: ______________________________

Dr. Donald J. Radomski, D.M.D, P.A.

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