PALM BEACH
Pediatric
Dentistry
INNOVATIVE CARE
FOR GROWING SMILES

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CHILD / CHILDREN'S NAME(S)	
Child Name:	Child DOB:
Child Name:	Child DOB:
Child Name:	Child DOB:
Child Name:	Child DOB:

MOTHER'S INFORMATION		
Name:		☐ *Step-Mother*
DOB:	*Marital Status:*	
Address:		
Employer:	*Occupation:*	
Cellular Phone:	Alt Phone:	
Email:		
Is child's address same as above? ☐ Yes ☐ No:		☐ *Responsible Party*

FATHER'S INFORMATION		
Name:		☐ *Step-Father*
DOB:	*Marital Status:*	
Address:		
Employer:	*Occupation:*	
Cellular Phone:	Alt Phone:	
Email:		
Is child's address same as above? ☐ Yes ☐ No:		☐ *Responsible Party*

Who may we thank for referring you to our office?	
Signature:	*Date*
Relationship:	

PRENATAL, MEDICAL & DENTAL HISTORY

1. Were there any medical events during pregnancy (ex: pre-term labor, pre-eclampsia, high blood pressure)

☐ No ☐ Yes, please explain:

2. Were any medications taken during pregnancy? ☐ No ☐ Yes, please explain:

3. Was the pregnancy full term? ☐ No ☐ Yes

4. Was birth natural or C-section? ☐ Natural ☐ C-section, please circle one: (emergency / scheduled)

5. Is this your first child? ☐ Yes ☐ No, birth order:

6. Did your child stay in the NICU? ☐ No ☐ Yes, please explain if there was oral or nasal intubation:

7. Did your child experience any chronic ear infections or fevers between 1-2 years old? ☐ No ☐ Yes

If yes, how many:

7a. Did your child have ear tube surgery? ☐ No ☐ Yes

7b. Did your child have their tonsils and adenoids removed? ☐ No ☐ Yes

8. Does your child have allergies? ☐ No ☐ Yes, please explain:

9. Was your child breast fed or formula fed? ☐ Formula Fed ☐ Breast fed - Any issues:

10. Does your child have any prior or current habits (ex: pacifier, bottle, thumb sucking)?

☐ No ☐ Yes, please explain:

11. Does your child have any of the following conditions?

- ☐ Abnormal Bleeding/Hemophilia
- ☐ Congenital Heart Disease
- ☐ Any Hospital Stays or Operations
- ☐ Hearing Impairment
- ☐ Convulsions/Epilepsy
- ☐ Heart Murmur
- ☐ Asthma/Reactive Airway Disease
- ☐ Rheumatic/Scarlet Fever
- ☐ Sensory/Processing Disorder
- ☐ Hepatitis/HIV/AIDS
- ☐ Cancer/Leukemia/Blood Disorder
- ☐ Handicaps/Disabilities/Special Needs
- ☐ Liver/Kidney Condition

11. Please list all drugs patient is currently taking:

12. Is this your child's first visit to the dentist? ☐ Yes ☐ No, how long since last visit:

13. Were there any x-rays taken at the last dental visit? ☐ No ☐ Yes

14. Have there been any injuries to your child's teeth/mouth/face? Is your child in any pain?

☐ No ☐ Yes, please explain

15. Is your child taking any supplements? ☐ No ☐ Yes

16. Name of Pediatrician: Phone Number:

I agree and understand that I am accompanying the child and I am financially responsible for this visit:

Signature _____ Date _____

DIET & EATING HABITS

1. What are your child's eating habits? ☐ Picky ☐ Sit Down ☐ Grazer

2. Please list some food your child normally eats:

☐ Dairy ☐ Dried Fruits ☐ Pasta ☐ Sticky Carbs ☐ Whole Fruits & Veggies

3. What does your child mainly drink? ☐ Water ☐ Other

4. Is most of your child's food home cooked? ☐ Yes ☐ No

5. How much processed food does your child eat? ☐ Very minimal ☐ 50% ☐ More than 50%

6. Is your child still nursing? ☐ Yes ☐ No

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date_____

BROKEN APPOINTMENTS

Since we set aside a special time in our schedule for your appointment, we kindly ask that I you are unable to keep your appointment please contact us 2 (two) business days in advance. Unfortunately if we do not receive advance notice, you will incur a minimum broken appointment charge of $55 per appointment.

Most importantly, please keep us informed of any insurance changes such as policy name, insurance company address, or change in employment.

_____ Date_____

Patient/Parent

MODEL RELEASE

At Palm Beach Pediatric Dentistry we would like to share your positive experience via photo/video! We love sharing our patient's smiles with others and we appreciate your participation.

I hereby release, discharge and agree to hold harmless the practice of Palm Beach pediatric Dentistry, PA, their legal representatives or assigns, and all persons acting under their permission or authority, from any liability. I hereby warrant that I have read the above authorization, prior to its execution, and I am fully familiar with the contents thereof.

*Please sign below if you give permission for your child's photo/video to be shared and you understand and agree to the above terms.

_____ Date_____

Patient/Parent