Cade Hunzeker, DDS, PC

Pediatric Dentistry

Patient ID # ____________________

Today's Date ____________________

Thank you for selecting us.

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name ____________________ Sex ________ Age ____________

Nickname ____________________ SS#/SIN ____________________ Birthdate ____________________

School ____________________ Grade ____________________

Child's Home Address ____

City ____________________ State/Prov. ______ Zip/P.C. _______ Phone ____________________

Whom may we thank for referring your child? ____

Responsible Party

Name ____________________ Relationship ____________________

Address ____________________ Email ____________________

City ____________________ State/Prov. _______ Zip/P.C. ____________________

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

Birthdate ____________________ SS#/SIN ____________________ DL # ____________________

Who is Responsible for Making Appointments? ____________________

Parent or Guardian Information ❑ Mother ❑ Stepmother ❑ Guardian

Name ____________________ Email ____________________

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

Employer ____________________ Occupation ____________________

Birthdate ____________________ SS#/SIN ____________________ DL # ____________________

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Parent or Guardian Information ❑ Father ❑ Stepfather ❑ Guardian

Name ____________________ Email ____________________

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

Employer ____________________ Occupation ____________________

SS#/SIN ____________________ DL # ____________________

Birthdate ____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Primary Dental Insurance

Policy Holder's name ____________________ Relationship ____________________

Birthdate ____________________ SS#/SIN ____________________

Employer ____________________ Date Employed __________ Occupation ____________________

Insurance Co. ____________________ Group # ______________ Employee # ______________

Ins. Co. Address ____________________ City ______________ State/Prov. _______ Zip/P.C. _________

Deductible ____________________ Copay __________ Amount already used __________ Max. annual benefit __________

Additional Dental Insurance

Policy Holder's name ____________________ Relationship ____________________

Birthdate ____________________ SS#/SIN ____________________

Employer ____________________ Date Employed __________ Occupation ____________________

Insurance Co. ____________________ Group # ______________ Employee # ______________

Ins. Co. Address ____________________ City ______________ State/Prov. _______ Zip/P.C. _________

Deductible ____________________ Copay __________ Amount already used __________ Max. annual benefit __________

infants,

children,

adolescents,

young adults,

Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? ______________________________

How often does your child floss? ______________________________

Is your child's water fluoridated? ❑ Yes ❑ No

Does your child take fluoride supplements? ❑ Yes ❑ No

Does your child:

- Suck Thumb/Finger ❑ Yes ❑ No
- Suck/Bite Lip ❑ Yes ❑ No
- Bite/Chew Nails ❑ Yes ❑ No
- Chew hard objects (pencils, etc.) ❑ Yes ❑ No
- Grind Teeth ❑ Yes ❑ No
- Clench Jaws ❑ Yes ❑ No
- Uses Pacifier ❑ Yes ❑ No

Date of last Dental Visit ______________________________

Previous Dentist ______________________________

Address ______________________________

Has your child had difficulty with previous dental visits? ❑ Yes ❑ No

Has your child ever taken Fen-Phen/Redux? ❑ Yes ❑ No

Patient ID #______________________________

Has your child ever had any of the following:

- Asthma ❑ Yes ❑ No
- Handicaps/Disabilities ❑ Yes ❑ No
- Cancer ❑ Yes ❑ No
- Tuberculosis ❑ Yes ❑ No
- Hepatitis ❑ Yes ❑ No
- Diabetes ❑ Yes ❑ No
- HIV/AIDS ❑ Yes ❑ No
- Rheumatic Fever ❑ Yes ❑ No
- Hemophilia ❑ Yes ❑ No
- Congenital heart Defect ❑ Yes ❑ No
- Abnormal Bleeding ❑ Yes ❑ No
- Heart Murmur ❑ Yes ❑ No
- Stomach, Liver or Kidney Problems ❑ Yes ❑ No
- Convulsions/Epilepsy ❑ Yes ❑ No
- Latex Allergy ❑ Yes ❑ No
- Drug Allergy (Penicillin, Novocaine, etc.) ❑ Yes ❑ No
- Other Allergies ❑ Yes ❑ No
  - If yes, please list ______________________________
- A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ❑ Yes ❑ No

Child's Physician ______________________________ Phone # ______________________________

Address ______________________________

Previous Hospitalization/Surgeries/Serious Illnesses or other medical conditions. When?

______________________________ ______________________________

______________________________ ______________________________

Is your child currently taking any medications? ❑ Yes ❑ No (if yes, please list)______________________________

Please explain any medical problems that your child has: ______________________________

____

Does your child require antibiotics before any dental visit? ❑ Yes ❑ No

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

❑ Cash ❑ Personal check Credit Card: ❑ VISA ❑ MasterCard ❑ I wish to discuss the office's payment policy.

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment of examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

______________________________ ______________________________

Signature of Patient (or Parent/Guardian if minor) Date

Dentist's Review: ______________________________

____

____

____

____

____

______________________________ ______________________________

Signature of Dentist Date