River Falls
PEDIATRIC DENTISTRY

The following information and history are necessary for the adequate treatment of your child. ***Thank you for completing all information in full.***

SOCIAL HISTORY

Patient's Full Name_____Preferred_____Age_____Sex_____

Race_____DOB_____Place of Birth_____School_____

Patient's SS#_____-_____-_____ Name and type of child's Pet_____ Favorite Interest/hobby_____

How do you expect your child to react to his/her visit today? ____Excellent____Good____Fair____Poor____Not sure

The Parent or Guardian that brings the child is responsible for the account.

Child lives with ____Both Parents ____Mother____ Father ____Stepmother ____ Stepfather ____ Grandparent ____Other: _____

Patient's Address_____City/State_____Zip_____

Father's Full name_____DOB_____SS#_____

His Address_____CityState_____Zip _____

Father's Home Phone_____Cell Phone_____Work Phone_____

Where Employed_____Address_____

Mother's Full Name_____DOB_____SS#_____

Her Address_____City/State_____Zip_____

Mother's Home Phone_____Cell Phone_____Work Phone_____

Where Employed_____Address_____

*Other Children in the family? Names and Ages*_____

How did you hear about us?_____ **Have you seen our Ad in Upstate Parent Magazine?**_____

Reason for bringing your child to the dentist?_____

INSURANCE INFORMATION:

Child is insured by:____Mom ____Dad ____Self ____Medicaid (Medicaid number)_____ Other_____

Insured Person's full name_____DOB_____Insured' s SSC#_____

Insurance Company Name/Address:_____City/State/Zip_____

Insurance ID#_____Group #_____Ins. Company phone number_____

EMERGENCY INFORMATION:

NAME:_____Phone_____Relationship to patient_____

Medical History:

Child's Physician_____Address_____Phone_____

Condition of Child's General Health_____Year of last physical_____

__ Yes __ No Were there any problems during pregnancy or birth of your child?_____

__ Yes __ No Are your child's immunizations up to date? If no, explain_____

__ Yes __ No Is your child allergic to any medications or foods? If yes, what?_____

__ Yes __ No Is your child taking any medications now? If yes , what?_____

__ Yes __ No Have you ever been told by a physician that your child requires antibiotics prior to dental treatment?_____

__ Yes __ No Has your child ever been hospitalized or had an operation? If yes, explain_____

__ Yes __ No Has your child received medical treatment within the last 6 months? If yes, explain_____

__ Yes __ No Does your child have any physical or mental disabilities? If yes, explain_____

__ Yes __ No Does your child have any hearing, sight, speech, or learning problems? If yes, explain_____

Please check any that pertain to your child (explain if applicable)

__ Heart/Cardiovascular	__ Cerebral Palsy	__ Hepatitis	__ Diabetes
__ Mental/Emotional Disorder	__ Rheumatic Fever	__ Asthma	__ Tuberculosis
__ Liver/Kidney Problem	__ Bleeding Disorder	__ Allergies	__ Transfusion
__ Nervous System Problem	__ Sickle Cell Anemia	__ Epilepsy	__ HIV/AIDS

__ Other Explain:_____

DENTAL HISTORY

__Yes __No Is this your childs first dental visit? If no, name of previous Dentist_____

__ Yes __No Are there any hereditary dental problems in the family (missing, extra teeth?),_____

__ Yes __No Has your child or any family member experienced and unfavorable reaction from previous dental treatment?_____

__ Yes __No Has your child ever received injuries to the head, mouth, jaws or teeth? _____

__ Yes __No Does your child have a thumb, finger or pacifier habit?_____

__ Yes __No Does your child take fluoride supplements_____Do you have a private well or public/city water?_____

Was your child breast or bottle fed?_____To what age?_____

I agree to diagnostic procedures and dental treatments found necessary and desirable by Dr. Chana Tocharoen, for the patient named above.
I do also authorize and request the administration of such anesthesia and/or sedatives as may be deemed advisable by the above named doctor.
I am aware that I will be informed of all services before any treatment is rendered to my child. I will accept responsibility for this account should named responsible party fail or insurance benefit be denied.

DATE: : _____SIGNATURE: _____

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