Arizona PEDIATRIC Dental Care

Dr. Jared Welch
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PATIENT INFORMATION

DATE: _____

Last Name_____ First Name _____ Middle I ____ Gender_____

Prefers to be addressed by _____ Date of Birth ____/____/____ Age _____

Address_____ Apt# _____

City _____ State _____ Zip _____ Home Telephone_____

Emergency Contact: Name_____ Telephone* _____

Other family members treated at this office _____

PARENTAL INFORMATION

Mother

Name_____

Date of Birth ____/____/____

Social Security# _____

Cell Phone#_____

Email _____

Single _____ Married _____

Widowed _____ Divorced _____

Separated _____ Guardian _____

Employer _____

Address _____

Telephone_____

Complete if *DIFFERENT*

Home Address _____

City_____State___ Zip _____

Home Telephone _____

Father

Name_____

Date of Birth ____/____/____

Social Security# _____

Cell Phone#_____

Email _____

Single _____ Married _____

Widowed _____ Divorced _____

Separated _____ Guardian _____

Employer _____

Address _____

Telephone _____

Complete if *DIFFERENT* from Patient's home information:

Home Address _____

City_____State___ Zip _____

Home Telephone _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Company _____

Address _____

City_____State___ Zip _____

Insurance Telephone _____

Policy/ Group# _____

Policy Holder_____

Relationship to Patient_____

Secondary Insurance

Company _____

Address _____

City_____State___ Zip _____

Insurance Telephone _____

Policy/ Group# _____

Policy Holder_____

Relationship to Patient_____

REFERRAL INFORMATION

How did you hear about our office?

_____

Patient's Name _____ *D.O.B.* _____

DENTAL HISTORY

Previous dentist (if any) _____ **Date of last dental exam** _____

What concerns you most about your child's dental health? _____

Does your child have dental pain? Y ____ N ____ Level of pain (1-10) _____

Mouth habits? (Please cheek) Thumb sucking _____ Pacifier _____ Mouth Breather _____

Still on bottle _____ Finger habit _____ Tooth grinding _____ None _____

Has your child had a negative dental experience in the past? _____

If yes, please explain _____

How often does your child brush? _____ **Floss?** _____

Has your child received fluoride supplements? Y ____ N ____ **If yes, what kind?** _____

Are you happy with the appearance of your child's teeth? _____

MEDICAL HISTORY

Name/Practice Name of childs pediatrician _____ **Phone #** _____

Is your child under the care of a physician at this time? Y ____ N ____

Explain: _____

Has your child ever had a serious illness or been hospitalized? Y ____ N ____ Date: _____

Explain: _____

Has you child ever had general anesthesia? Y ____ N ____

Explain: _____

Are all your child's immunizations current? Y ____ N ____

Has your child ever been advised to take an antibiotic prior to any dental treatments? Y ____ N ____

If yes, antibiotic name and method: _____

Is your child taking any medication? Y ____ N ____ If yes, what: _____

Does your child have allergies? (medications, food, latex, seasonal etc.) Y ____ N ____

If yes, what: _____

Please answer the following. Has your child ever had a history of:

Y	N		Y	N	
❑	❑	ADD/ADHD	❑	❑	Heart Condition (type? _____)
❑	❑	AIDS or H.I.V. Positive	❑	❑	Heart Murmur
❑	❑	Anemia	❑	❑	Heart Pacemaker
❑	❑	Artificial Heart Valve	❑	❑	Heart Surgery date: _____
❑	❑	Asthma	❑	❑	Hemophilia (type? _____)
❑	❑	Autism	❑	❑	Hepatitis (type? _____)
❑	❑	Birth defects	❑	❑	Jaw Pain
❑	❑	Blood Disorders /Bleeding Problems _____	❑	❑	Kidney Trouble
❑	❑	Brain Injury	❑	❑	Leukemia
❑	❑	Cancer	❑	❑	Liver Disease
❑	❑	Cerebral Palsy	❑	❑	Psychiatric Treatment
❑	❑	Cleft lip/Palate	❑	❑	Respiratory Lung Disease
❑	❑	Developmental Delayed	❑	❑	Rheumatic Fever
❑	❑	Diabetes	❑	❑	Scoliosis
❑	❑	Earaches	❑	❑	Sickle Cell
❑	❑	Emotional Problems	❑	❑	Speech Problems
❑	❑	Epilepsy (seizures)	❑	❑	Syndrome (type? _____)
❑	❑	Fainting Spells	❑	❑	Tonsillitis
❑	❑	Headaches	❑	❑	Tuberculosis
❑	❑	Hearing/Sight Impaired	❑	❑	Ulcers

❑ Other: _____

Is there any other information that we should know about your child's health? _____

I certify that the information given is correct and give consent to Arizona Pediatric Dental Care to treat my child.

Signature _____ Date _____

(Please Circle One) Parent Guardian Other

Reviewed By _____ Date _____

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