Welcome!

Frederick Pediatric Dentistry, LLC

Pediatric Dentists: Drs. Joseph Camacho and Associates

Today's Date: _____

Whom may we thank for referring you, or how did you hear about our practice? _____

Please tell us about your child:

Child's Name: _____ ☐Male ☐Female

Nickname: _____

Child's Birthdate: _____ Age _____

Child's Home Phone: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Is the child adopted? ☐ Yes ☐ No

If "yes," date of adoption: _____

Is the child in a foster home? ☐ Yes ☐ No

If "yes," name of foster home: _____

Who is accompanying the child today?

Name: _____

Relation: _____

Do you have legal custody of the child? ☐ Yes ☐ No
If "no," please indicate the following information regarding the individual who has custody:

Name: _____

Relation: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Dental Insurance:

Name of Policyholder: _____ DOB: _____

Relation to Patient: _____

Insurance Company: _____

Address: _____

Plan Number: _____ Group Number: _____

Phone Number: _____

Parent's Information:

Marital Status: _____

Mother's Name: _____

DOB: _____

Social Security #: _____

Address: (Same as Child), or:

_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

E-Mail: _____

Father's Name: _____

DOB: _____

Social Security #: _____

Address: Address: (Same as Child), or:

_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

E-Mail: _____

Person Responsible for Account:

☐Same as above information (☐ Father ☐ Mother)

Or Other:

Name: _____

DOB: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

E-mail Address: _____

Medical Information:

Name of Pediatrician: _____ Phone Number of Pediatrician: _____

Are your child's immunizations current? ☐ Yes ☐ No Has your child ever been hospitalized? ☐ Yes ☐ No

Does your child need to be premedicated before dental treatment due to a heart condition or other medical condition? ☐ Yes ☐ No

Does your child have tubes in his/her ears as a result of multiple ear infections? ☐ Yes ☐ No

Is your child allergic to any medications? ☐ Yes ☐ No **If "yes," please list:** _____ **Is your child allergic to Latex?** ☐ Yes ☐ No

Please list all medications, including vitamins and herbal supplements, that your child is currently taking: _____

Is your child allergic to PEANUTS, TREE NUTS, or PINE? ☐ **Yes** ☐ **No** ☐ **Don't Know**

Please place a check next to (or circle) any of the medical conditions your child has:

ADD	Cardiac Surgery	Fainting	Liver Disease	Special Condition (see below)
ADHD	Ceclor Allergy	Genetic Disorder	Mental Disorders	Specific Allergy (see below)
Allergies	Cephalosporin Allergy	Hay Fever	Migraines	Seizures
Amoxicillin Allergy	Cerebral Palsy	Head Injuries	Nervous Disorders	Sensory Int. Disorders
Anemia	Codeine Allergy	Hearing Problems	Other Drug Allergy	Sinus Problems
Arthritis	Depression	Heart Disease	Pacemaker	Speech Delay
Artificial Joints	Diabetes	Heart Murmur-Significant	Penicillin Allergy	Stomach Problems
Asperger Syndrome	Developmental Delay	Heart Murmur-Innocent	Pregnant	Stroke
Asthma	Dizziness	Hepatitis	Radiation Treatment	Sulfa Allergy
Augmentin Allergy	Down Syndrome	High Blood Pressure	Reflux	Tuberculosis
Autism	Epilepsy	Kidney Disease	Requires Antibiotics	Tumors
Blood Disease	Erythromycin Allergy	Latex Allergy	Respiratory Problems	Ulcers
Cancer	Excessive Bleeding	Learning Disability	Rheumatic Fever	Other Condition (see below)

Please describe any condition your child has that is not listed above, or requires additional information:

_____

Pediatric Dental Information:

Is your child currently in pain? ☐ Yes ☐ No What brings you to see us today? _____

Name of Previous Dentist: _____ Location of Previous Dentist: _____ Date of Last Dental Visit: _____

How often does your child brush his/her teeth? _____ How often does your child floss his/her teeth? _____

Is your child's drinking water fluoridated? ☐ Yes ☐ No Does your child take fluoride supplements? ☐ Yes ☐ No

Has your child ever had dental x-rays? ☐ Yes ☐ No If "yes," approximate date of last x-rays: _____

Has your child ever had an unpleasant experience with a dentist? ☐ Yes ☐ No If "yes," please briefly describe: _____

Has your child ever received local anesthesia (numbing) for dental treatment? ☐ Yes ☐ No

For dental care, has your child ever been (circle): Given Laughing Gas Sedated Hospitalized

Please circle any habits your child currently has:

Chewing on Objects/Toys	Nail Biting	Tongue/Cheek Biting	Nursing /Bottle	Lip Sucking/Biting	Speech Problems
Clenching Teeth	Pacifier past 12 months of age	Mouth Breathing	Thumb/Finger Sucking	Tongue Thrust while swallowing	Grinding Teeth

The information I have provided in this form is true to the best of my knowledge. I understand that giving inaccurate information regarding the medical status of my child may be harmful to their health. I authorize Frederick Pediatric Dentistry, LLC to perform the recommended dental treatment for my child.

Parent/Guardian Signature: _____ **Printed Name:** _____ **Date:** _____

DDS/RDH Signature : _____ **Date:** _____