FAIRFIELD
1246 Nilles Rd.
Fairfield, OH 45014
☎ *(513) 858-6575*

FAIRFIELD PEDIATRIC DENTISTRY
CHEW CHEW JUNCTION

OXFORD
508 S. Locust St.
Oxford, OH 45056
☎ *(513) 523-8289*

CHILD'S NAME ____________________ BIRTH DATE ____________ SEX ______ AGE ______

GUARDIAN #1 NAME ____________________ BIRTH DATE ____________ S.S. # ____________

GUARDIAN #1 ADDRESS ____________________ CITY ____________ STATE ______ ZIP ______

GUARDIAN #1 EMPLOYER ____________________ HOME PHONE ____________________

CELL PHONE ____________________ WORK PHONE ____________________

EMAIL ADDRESS ____

GUARDIAN #2 NAME ____________________ BIRTH DATE ____________ S.S. # ____________

GUARDIAN #2 ADDRESS ____________________ CITY ____________ STATE ______ ZIP ______

GUARDIAN #2 EMPLOYER ____________________ HOME PHONE ____________________

CELL PHONE ____________________ WORK PHONE ____________________

EMAIL ADDRESS ____

CHILD'S MEDICAL DOCTOR ____________________ LAST VISIT ____________________

REASON ____

NAME OF PRIMARY DENTAL INSURANCE ____________ NAME OF SECONDARY DENTAL INSURANCE ____________

NAME OF INSURED ____________________ NAME OF INSURED ____________________

INS. I.D. # ____________________ INS. I.D. # ____________________

WHOM MAY WE THANK FOR THIS REFERRAL? ____

HOW DID YOU LEARN ABOUT THIS OFFICE? ____

• •

PLEASE READ CAREFULLY:

BECAUSE YOUR CHILD IS A MINOR, IT BECOMES NECESSARY THAT A SIGNED PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY/AND ALL NECESSARY DENTAL SERVICES CAN BE STARTED AND ACCOMPLISHED BY THE DOCTORS HERE AT FAIRFIELD PEDIATRIC DENTISTRY.

AUTHORIZATION IS HEREBY GRANTED AS SUCH. FURTHERMORE, I WILL BE RESPONSIBLE FOR ANY FEE CHARGED FOR THIS DENTAL AGREEMENT. I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO DENTAL CLAIMS TO MY INSURANCE COMPANY.

**** NOTE: OUR OFFICE POLICY IS THAT ALL ACCOUNTS ****
WILL BE BILLED TO THE GUARDIAN
AUTHORIZING DENTAL TREATMENT

Signature ______________________________ Relationship ____________________ Date ____________

******** PLEASE TURN OVER ********

MEDICAL INFORMATION

Please read and answer EACH question. Please check (✓) if your child has had any problem or history of the following. If you need assistance, we will be glad to help you.

	YES	NO
1. Abnormal bleeding problems	____	____
2. Allergies	____	____
a) To any medications (drugs)	____	____
b) Latex	____	____
c) Other	____	____
3. Anemia	____	____
4. Anxiety or Depression	____	____
5. Arthritis	____	____
6. Asthma	____	____
7. Autism Spectrum	____	____
8. Bladder Issues	____	____
9. Cerebral palsy	____	____
10. Convulsions or seizures	____	____
11. Cystic Fibrosis	____	____
12. Developmental Delays	____	____
13. Diabetes	____	____
14. Emotional problems	____	____
15. Fainting	____	____
16. Hearing problems	____	____
17. Heart problems or murmur	____	____
18. Hepatitis	____	____
19. Hyperactivity or ADHD	____	____
20. Immune Deficiency	____	____
21. Kidney disorders	____	____
22. Learning disabilities	____	____
23. Liver disorders	____	____
24. Malignancy or leukemia	____	____
25. MTHFR gene mutation	____	____
26. Pregnancy	____	____
27. Sensory Processing Disorder	____	____
28. Special needs	____ Physical	____ Mental
29. Speech Delay	____	____
30. Tuberculosis	____	____
31. Vomiting, GERD, Reflux	____	____

If any of the above are checked "YES", please give a brief explanation: _____

_____

Is your child presently taking any medications?_____ If so, what and prescribed by whom?_____

_____

_____

Has your child ever taken penicillin or amoxicillin?_____ Any allergic reactions?_____

Has your child ever been hospitalized?_____ If so, for what reason?_____

_____

Has your child ever had surgery or received any transfusions of blood, blood products or blood elements?_____

_____

Does your child have any medical problems not listed above?_____

_____

DENTAL INFORMATION

Last visit to a Dentist _____

Current dental problem? _____

Any unhappy dental visits?_____

Any injuries to the mouth, teeth, or head?_____

Any mouth habits (thumb-sucking, etc.)?_____

Has your child had X-Rays before?_____

Has your child had toothaches in the past?_____