TEXAS PEDIATRIC DENTISTRY

*Patient Name:*_____ *Date of birth:* _____

DEMOGRAPHIC INFORMATION

Mother's Name_____ Mother's Occupation_____ Phone_____

Father's Name_____ Father's Occupation_____ Phone_____

Do we have your permission to leave a detailed message on the phone numbers listed? Yes No

Please list any other people who you would like us to share patient PHI with and allow them to accompany the patient to appointments:

Name/Relationship to patient: _____

Protected Health Information ("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing.

Home Address_____

Email Address_____

Who has legal custody of patient? Mom Dad Both Other_____

Who is the person responsible for this account? _____

Does the patient attend school, daycare, home schooled, preschool, or stay at home?_____

If patient goes to school- where and what grade?_____

If child is in school, do they receive any special services like speech therapy?_____

How did you hear about us?_____

DENTAL HISTORY

Has your child ever been to the dentist? Yes No

Name of dentist and how long since last appointment?_____

Has your child experienced any unfavorable reaction from previous dental care? Yes No

Has your child had an orthodontic consultation? Yes No

If your child is currently in orthodontics, with whom? _____

Does your child use fluoride toothpaste? Yes No

Do you give your child any other form of fluoride? Yes No What?_____

How often does your child brush their teeth and does anyone help them?_____

Does your child floss? Yes No How Often?_____

Please circle if the patient is having problems with any of the following:

Cavities/fillings	Toothache/Sensitive	Halitosis/Bad Breath	Trauma	Sucking Habit (Thumb, etc.)	
Gum Infections	Color of Teeth	Orthodontic Hygiene	Jaw Discomfort	Grinding	Other

_____ _____

Parent/Guardian Signature *Date*