Children's Crossing Pediatric Dentistry
1528 N Commerce Drive Suite 100
Saratoga Springs, UT 84045 Date:_____

Patient Information

Name: _____ Preferred Name: _____ Male / Female

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Whom may we thank for referring you to our office? _____

Parent's Marital Status: _____ Married _____ Single _____ Divorced _____Widowed

Tell us about your Child's Dental History

Why did you bring your child to the dentist today?_____

Is this your child's first dental visit? Yes No Name of previous dentist: _____ Last visit date_____

How do you think your child will behave today? (Check all that may apply)

___ friendly ___ happy ___ anxious ___ timid ___ afraid ___ resistant ___ combative

Has your child ever has a serious/difficult problem associated with previous dental work? Yes No

Is your child's water fluoridated? Yes No Is your child taking fluoride supplements? Yes No

Does your child brush his/her teeth daily? Yes No Floss daily? Yes No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Are you happy with the appearance of your child's teeth? Yes No Explain if no _____

Does your child have any of the following habits?

Y N Lip Sucking/Biting Y N Nail Biting Y N Nursing/Bottle Habits Y N Thumb/Finger Sucking

Tell us about your Child's Medical History

Has your child had a history or difficulty with any of the following? If yes to any, please describe below.

Y	N	Abnormal Bleeding	Y	N	Diabetes	Y	N	Kidney/Liver Problems
Y	N	Any Blood Disease or Anemia	Y	N	Eye, Ear, Nose, Throat Problems	Y	N	Mental or Learning Delay
Y	N	Allergies to any drugs (list below)	Y	N	Gag Reflex	Y	N	Other Heart Ailment
Y	N	Asthma	Y	N	Handicaps/Disabilities	Y	N	Premature Birth
Y	N	Brain Injury	Y	N	Hearing Impairment	Y	N	Rheumatic Fever
Y	N	Cancer or Malignancies	Y	N	Heart Murmur	Y	N	Speech Disorder
Y	N	Cerebral Palsy	Y	N	Hemophilia	Y	N	Tuberculosis (TB)
Y	N	Congenital Heart Defect	Y	N	Hepatitis	Y	N	Tumors or Growths
Y	N	Convulsions/Epilepsy	Y	N	HIV/AIDS			Other, explain below

If Heart Condition present, does your child require an antibiotic premed prior to having certain procedures done? Yes / No

Name of child's physician _____ Phone #: _____

Is your child under doctor's care now? Yes No For what reason?_____

Please list all drugs or medications your child is currently taking: _____

Has your child had any serious medical problems? _____

Has your child ever been hospitalized and/or had operations? Yes No Reason: _____

Please list all drugs your child is allergic to: _____

If you answered yes to any questions above, please give any additional information necessary. _____

_____

_____

Parent/Guardian Information

Mother (full name) _____

Check if you are Mother ____ Step Mother ____ Legal Guardian ____ Other _____

Address _____ City _____ State _____ Zip _____

Hm phone: _____ Wk phone: _____X _____ Cell: _____

SS #: _____ Drivers License St & # _____ Date of Birth _____

E-mail: _____ Employer: _____

Father (full name) _____

Check if you are Father ____ Step Father ____ Legal Guardian ____ Other _____

Address _____ City _____ State _____ Zip _____

Hm phone: _____ Wk phone: _____X _____ Cell: _____

SS #: _____ Drivers License St & # _____ Date of Birth _____

E-mail: _____ Employer: _____

Nearest relative not living with you. Name _____ Phone #: _____

Relationship to patient _____

Primary Dental Insurance Information

Insurance Company _____

Address _____

_____

Phone: _____

Group #: _____

Subscriber's Name: _____

Subscriber's ID #: _____

Subscriber's Date of Birth: _____

Employer: _____

Secondary Dental Insurance Information

Insurance Company _____

Address _____

_____

Phone: _____

Group #: _____

Subscriber's Name: _____

Subscriber's ID #: _____

Subscriber's Date of Birth: _____

Employer: _____

* Please be aware, secondary insurance may not cover the balance of charges after your primary insurance pays. You may have a portion to pay for treatment.

PLEASE NOTE: Your insurance is billed as a courtesy; you are responsible for your child's account

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the Children's Crossing Pediatric Dentistry and associates to perform the necessary dental services my child may need.

_____ _____

Signature of Parent or Legal Guardian Date