Blue Stone Hills
DENTISTRY

Your family's best interest is our only interest!

Pediatric Patient Information (all information given is confidential)

Today's Date _____

Patient's Name _____ Home Phone Number (_____) _____-_____

Patient's Gender_____ Social Security Number _____

Birth date _____ Address _____

City _____ State _____ Zip Code _____

Responsible Party

Name of Person Responsible for this Account _____

Relationship to Patient _____ Address _____

City _____ State _____ Zip Code _____

Home Phone Number (_____) _____-_____ Cell Phone Number (_____) _____-_____

Email Address _____

Social Security Number _____ Driver's License Number _____

Employer _____ Work Phone Number (_____) _____-_____

Email _____

Cell Phone Number (_____) _____-_____

For receiving appointment reminders, you prefer to be contacted by (check which applies best)

☐ Home Phone Call ☐ Cell Phone Call ☐ Text Reminder ☐ Email Reminder

Is this person currently a patient in our office? ☐ Yes ☐ No

Are there other family members involved in your child care/can receive information regarding dental care? ☐ Yes ☐ No

If yes, please give relationship and contact information:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone Number (_____) _____-_____ Cell Phone Number (_____) _____-_____

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone Number (_____) _____-_____ Cell Phone Number (_____) _____-_____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is expected at the end of each appointment.

☐ Cash ☐ Personal Check ☐ Credit Debit Card(Visa/Mastercard/Discover/AE)

Insurance Information

Named of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security Number _____

Name of Employer _____ Date of Employment _____

Union or Local Number (if any) _____ Work Phone Number _____

Address of Employer _____ City _____

State _____ Zip Code _____

Insurance Company _____ Group # _____ Policy ID # _____

Insurance Co. Address _____ City _____ State _____

Zip Code _____

Patient Medical History

Although dental personnel primarily treat the area in and around the mouth, your child's mouth is part of their entire body. Health problems that your child may have, or medications that he/she may be taking, could have an important interrelationship with the dentistry they receive. Thank you for answering the following questions.

Physician _____ Office Phone (_____) _____-_____
Date of Last Exam _____

Is your child under a physician's care currently? ☐ Y ☐ N

If yes, please explain:

_____

_____

Has your child been hospitalized for any surgical operation or serious illness in the last 5 years?

☐ Y ☐ N

If yes, please explain:

_____

_____

Please list all current medications for your child.

_____

_____

Have you ever been told your child needs to premedicate prior to dental care? ☐Y ☐N

Does your child have any known allergies? ☐ Y ☐ N

If so please list: _____

_____

Is your child on a special diet? ☐ Y ☐ N

Does your child have or has had any of the following?

	Yes	No		Yes	No
AIDS/HIV	□	□	Blood Transfusion	□	□
Alzheimer's Disease	□	□	Breathing Problems	□	□
Anaphylaxis	□	□	Bruise Easily	□	□

Anemia	□	□	Cancer	□	□
Angina	□	□	Chemotherapy	□	□
Artificial Heart Valve	□	□	Low Blood Pressure	□	□
Artificial Joint	□	□	Lung Disease	□	□
Asthma	□	□	Mitral Valve Prolapse	□	□
Blood Disease	□	□	Pain in Jaw Joints	□	□
Cortisone Therapy	□	□	Parathyroid Disease	□	□
Diabetes	□	□	Psychiatric Care	□	□
Drug Addiction	□	□	Radiation Treatments	□	□
Easily Winded	□	□	Recent Weight Loss	□	□
Emphysema	□	□	Renal Dialysis	□	□
Epilepsy or Seizures	□	□	Rheuamtic Fever	□	□
Excessive Bleeding	□	□	Rheumatism	□	□
Excessive Thirst	□	□	Scarlet Fever	□	□
Fainting Spells/Dizziness	□	□	Shingles	□	□
Frequent Cough	□	□	Sickle Cell Disease	□	□
Frequent Diarrhea	□	□	Sinus Trouble	□	□
Frequent Headaches	□	□	Spina Bifida	□	□
Genital Herpes	□	□	Stomach/Intestinal Disease	□	□
Glaucoma	□	□	Stroke	□	□
Hay Fever	□	□	Swelling of Limbs	□	□
Heart Attack/Failure	□	□	Thyroid Disease	□	□
Heart Murmur	□	□	Tonsilitis	□	□
Heart Pace Maker	□	□	Tuberculosis	□	□
Heart Trouble/Disease	□	□	Tumors or Growths	□	□
Hemophilia	□	□	Ulcers	□	□
Hepatitis A	□	□	Venereal Disease	□	□
Hepatitis B or C	□	□	Yellow Jaundice	□	□
High Blood Pressure	□	□			
Hives or Rash	□	□			
Hypoglycemia	□	□			
Irregular Heartbeat	□	□			
Kidney Problems	□	□			
Leukemia	□	□			

Patient Dental History

How often does your child brush? _____

How often does your child floss? _____

Date of last dental check-up _____

Previous dentist _____

Do you have any concerns for your child's teeth? □ Yes □ No

If so, please explain: _____

_____

	Yes	No
Is your child's water fluoridated?	□	□
Does your child suck his/her thumb or fingers?	□	□
Does your child grind or clench their teeth?	□	□
Does your child currently take a fluoride supplement?	□	□

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved.

This office participates out-of-network with insurance, and I understanding I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to this dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform the office of any changes to my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X_____

Signature of patient (or parent/guardian if minor)