

Union Pediatric Dentistry

Dr. William Greenhill
2012 Callie Way, Suite 202
Union KY 41091

(859)384-6050

Patient Name:
Last First MI Preferred Name

Patient's date of birth

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please list all medications your child is currently taking, including prescriptions, over the counter medications and/or herbal remedies:

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Please list all hospitalizations/surgeries your child has had:

Please mark any of the following to indicate Yes in response to the question:

- | | |
|---|---|
| <input type="checkbox"/> Abnormal bleeding/bruising | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Other respiratory problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy/convulsions/seizures | <input type="checkbox"/> Blood pressure problems |
| <input type="checkbox"/> Heart problems/murmurs | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Leukemia/cancer | <input type="checkbox"/> Immune problems |
| <input type="checkbox"/> Radiation therapy/chemotherapy | <input type="checkbox"/> AIDS or HIV infection |
| <input type="checkbox"/> Kidney diseases | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Vision problems (other than glasses) |
| <input type="checkbox"/> Liver disease/hepatitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Sickle cell trait | <input type="checkbox"/> Behavioral/emotional problems |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Learning disorders |
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Mental retardation |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Bladder disorders | <input type="checkbox"/> Kidney disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Joint replacements or implants |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Stomach or other GI problems |
| <input type="checkbox"/> Syndromes | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Hay fever/environmental allergies | <input type="checkbox"/> Feeding problems |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Other problems not listed |
| <input type="checkbox"/> Allergies to penicillin or other antibiotics | <input type="checkbox"/> Codeine allergy |
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Allergy to local anesthetic |
| <input type="checkbox"/> Other known drug allergies (Please list) | |

If any of the previous questions are marked, please explain:

Does your child have any pain today? On a scale of 1 (low) to 10 (high), how would you rate the pain?

- Yes No

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Has your child had any traumatic injuries to the teeth?

Yes No

Do you have any dental concerns that we should be made aware of today?

Yes No

Please explain:

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____

Date:

Relationship to Patient:

Response Date: