

Jennifer Criss, D.D.S., P.A.
Nacogdoches Pediatric Dentistry

Date: _____

Patient Name _____ Nickname _____

Address _____ City _____

Home Phone _____ Zip Code _____ Gender Male Female

Social Security Number _____ Birth date _____ Age _____

Mother's Name _____ SS# _____

Employer _____ Work Phone _____ Cell phone _____

Father's Name _____ SS# _____

Employer _____ Work Phone _____ Cell phone _____

INSURANCE INFORMATION

Name of Insured _____ Employer: _____

Drivers Lic# _____ DOB _____ SS# _____

Insurance Carrier _____ Group # _____

Please present the front desk with a copy of your current dental insurance card.

Who has legal custody of this patient? _____

How did you hear about our office? _____

What is the reason for your child's visit today? _____

Health History

Name of child's physician _____ Date of last physical exam _____

Yes No Is your child in good health?

Yes No Has your child ever had a health problem?

List _____

Yes No Has your child ever been hospitalized?

Please give reasons and dates _____

Yes No Is your child allergic to any medications or foods (e. latex, penicillin, bananas)?

Please List _____

Yes No Is your child currently taking any medications?

Please list medication & reason _____

Yes No Were there any problems at birth?

List _____

Do you consider your child's development & learning to be: advanced normal slow

Child's Developmental Age (if known) _____

Please check if your child has been treated for any of the following:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bleeding/ blood transfusions | <input type="checkbox"/> Asthma | <input type="checkbox"/> LATEX allergy | <input type="checkbox"/> Autism/PDD |
| <input type="checkbox"/> Liver/GI disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Asperger's |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental delays | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Speech/hearing | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Physical delays | <input type="checkbox"/> Eyes/Vision |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Congenital birth defects | <input type="checkbox"/> Personality/social | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Genetic disorder |
| <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Recurrent headaches | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Tubes/Ear infections | <input type="checkbox"/> Other problems |

Please elaborate on any items checked:

Names & Ages of Siblings _____
 Child's Hobbies, Pets, & Interest _____
 Favorite Snack Foods _____
 School _____ Grade _____ Daycare _____

Dental History

- Yes No Has your child ever been to the dentist? Name of dentist and date _____
- Yes No Has your child experienced any unfavorable experiences or reactions to previous dental care?
 Explain _____
- Yes No Does your child suck a finger, thumb, or pacifier? _____
- Yes No Is your child having any dental pain? Location of pain _____
- Yes No Are you & your child happy with your child's smile?
 Describe your concerns: _____
- Yes No Is your child active in sports? List _____
- Yes No Does your child wear an athletic mouthguard while playing sports?
- Was your child breast fed bottle fed At what age was it discontinued? _____
- Who brushes your child's teeth? _____

Please check if your child is having problems with any of the following:

- Cavities Toothache/Pain Sensitive Teeth
- Trauma Gum Infections Color of teeth
- Orthodontics/Crowding Jaw Sounds Other

Comments: _____

Fluoride History

- Yes No Is your home water supply fluoridated?
- Yes No Does your child use a fluoride toothpaste?
- Yes No Do you give your child any other form of fluoride?

Office Use Only
<input type="checkbox"/> FI- City Water
<input type="checkbox"/> Pvt. Well
<input type="checkbox"/> Public Well _____ppm
<input type="checkbox"/> H ₂ O test kit given

Consent for Dental Treatment

I request and authorize Dr. Criss & her staff to examine, clean, and provide dental treatment on my child's teeth. I further request & authorize the taking of dental x-rays as may be considered necessary by Dr. Criss to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic & educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Criss & her staff will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation & demonstration of procedures & instruments, & using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment. I understand that the estimated portion of the treatment amount is due at the time of service and that any amount left unpaid by insurance is my responsibility to pay within 60 days. I hereby authorize payment of dental insurance benefits, if any, to be made directly to Jennifer Criss, DDS, PA, dba Nacogdoches Pediatric Dentistry. **Form will also be signed electronically.**

Signature _____ Date _____

I give my permission for the following adults to accompany my child to future dental *appointments* & make treatment decisions concerning my child when I am not present.

Name _____ Phone # _____ Relationship _____

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