

Central Texas Pediatric Dentistry, PA

Steven J. Hernandez, DDS
Board Certified Pediatric Dentist

Joy Angie Hernandez, DDS
Board Certified Pediatric Dentist

NEW PATIENT INFORMATION

A LEGAL GUARDIAN FOR THE CHILD MUST COMPLETE THIS FORM.

By completing this form thoroughly, you are assisting us to provide the most friendly, safe and efficient care for your child.

Person completing form _____ Relation to child _____ Date _____

Child Information

Child's name (First) _____ (Middle Initial) _____ (Last) _____ Male / Female

Preferred Name _____ Child's date of birth _____ Home phone number _____

Home address _____

City _____ State _____ Zip Code _____

If your child attends school, where _____ Grade _____

Child's physician or pediatrician _____ Phone number _____

Siblings? If yes, please list name and age _____

Sometimes we make conversation with children by talking about upcoming holidays, cartoon characters, tooth fairy, etc. Is this okay with you? Yes _____ No _____

Is there a favorite something we can talk to your child about? _____

Parent Information

Parent#1 Name (First) _____ (Middle Initial) _____ (Last) _____

Parent #1 Date of birth _____ Social Security # _____ Mobile Number _____

Parent#1 Occupation _____ Employer _____ Work phone # _____

Parent#2 Name (First) _____ (Middle Initial) _____ (Last) _____

Parent #2 Date of birth _____ Social Security # _____ Mobile Number _____

Parent#2 occupation _____ Employer _____ Work phone number _____

Phone number to **text** confirming appointments _____ and Email address _____

Who referred you to our office? _____ Family dentist name _____

Financial Information

Person responsible for child's account _____ Relation to child _____

Does the patient have dental insurance? Yes _____ No _____

Insurance company name _____ Phone number _____

During your visit we will only collect what we estimate your insurance will not pay. Actual insurance reimbursement may vary from our estimate. You are responsible for the full balance on your account. In the case of divorce or separation the parent that brings the child in for the visit is responsible for payment at the time of the visit. Please see our insurance specialist with any questions. I have read and understand this insurance policy. I also hereby authorize my insurance company to send payments directly to Steven J. Hernandez, DDS and Joy Angie Hernandez, DDS and understand that I am responsible for all remaining balances.

X

Signature

Date

First Visit Expectations

Reason for visit _____

Is this your child's first dental visit? Yes or No If no, when was last visit? _____

Has your child had dental x-rays in the past six months? Yes or No

Who was your child's last dentist? _____

What is your main concern about your child's dental health? _____

Has your child ever complained about a dental problem, or had any unhappy dental experiences? Yes or No

If yes, please explain. _____

Is your child presently having any dental problems? Yes or No If yes, please explain. _____

Medical History

Circle the answer that applies or fill in the blanks as needed.

- | | | | | | |
|------------|-----------|--|------------|-----------|------------------------------|
| Yes | No | Allergies to food or drugs _____ | Yes | No | Headaches |
| Yes | No | Seasonal allergies | Yes | No | Kidney, GI or liver disease |
| Yes | No | Anemia | Yes | No | Lung or breathing problems |
| Yes | No | Asthma | Yes | No | Mental disorder |
| Yes | No | Bleeding disorder | Yes | No | Rheumatic fever |
| Yes | No | Cerebral Palsy | Yes | No | Seizures |
| Yes | No | Diabetes | Yes | No | Speech disorder |
| Yes | No | Epilepsy | Yes | No | Tonsil or adenoid problems |
| Yes | No | Frequent infections | Yes | No | Snoring |
| Yes | No | Hearing disorder | Yes | No | Congenital birth defects |
| Yes | No | Behavioral or learning problems | Yes | No | Mental or physical delays |
| Yes | No | Endocrine problems | Yes | No | Problems with sight |
| Yes | No | Cancer | Yes | No | Diseases of blood |
| Yes | No | Allergy to wool or lanolin | Yes | No | Blood transfusion |
| Yes | No | Heart problems (including heart murmur) | Yes | No | Immunizations current |

Yes **No** **Latex allergy (reaction to balloons, pacifiers or any rubber goods). If yes, please explain** _____

Yes No Any other medical issues. If yes, please describe _____

Yes No Hospitalized. If yes, please describe _____

Yes No Any family members have any of the problems listed above. If yes, please describe (and include the relationship to child) _____

Yes No I would consider my child to be in good health. If no, please explain _____

Yes No I expect my child to cooperate for dental treatment.

Please list any medication (including dosage and frequency) your child takes _____

Please list any drugs that have caused adverse reactions in your child _____

Is there any other information that you feel might be of value to us in treating your child? _____

Dental History

Please be specific when marking the following information about your child. Circle the answer that applies or fill in the blanks as needed.

- | | | | | | |
|-----|----|---|---|----|-------------------------------------|
| Yes | No | TMJ/TMD (clicking or "popping" in the jaw) | Yes | No | City water |
| Yes | No | Finger habit | Yes | No | Fluoride supplement dosage _____ |
| Yes | No | Thumb habit | Yes | No | Fluoridated toothpaste |
| Yes | No | Other habit (_____) | Yes | No | Breastfed when stopped _____ |
| Yes | No | Nail biting | Yes | No | Bottle when stopped _____ |
| Yes | No | Mouth breathing | Yes | No | Pacifier when stopped _____ |
| Yes | No | Has your child ever worn an orthodontic appliance? | Yes | No | Is your child assisted in brushing? |
| Yes | No | Has your child received any fluoride treatments? | Yes | No | Is your child assisted in flossing? |
| Yes | No | Does your child get "cold sores" or "fever blisters"? | Yes | No | Are disclosing solutions used? |
| Yes | No | Has your child inherited any dental conditions? | How often are your child's teeth brushed? _____ | | |
| Yes | No | Does anyone in the family have missing teeth? | How often are your child's teeth flossed? _____ | | |
| Yes | No | Does anyone in the family get "cold sores" or "fever blisters"? | | | |
| Yes | No | Has your child ever had a dental injury (bumped or chipped tooth, bruised lip, etc.)? If so, please explain _____ | | | |

Is there any other information you would like us to know prior to your child's visit? _____

The information listed on both sides of this form is complete and accurate. I give consent for Dr. Steven Hernandez and Joy Angie Hernandez, Associates and staff to perform a dental examination, dental prophylaxis, fluoride treatment and take x-rays on my child.

X

Parent or Guardian

Date