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**