

# TURNER

Today's Date \_\_\_\_\_

## Pediatric Dentistry

We are so pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you.  
We look forward to working with you in maintaining your child's dental health!

### PATIENT INFORMATION

Child's Name: \_\_\_\_\_  
 Last First Middle Nickname  
 Male  Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Hobbies: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Street Apt.# City State Zip  
 Home Phone #: \_\_\_\_\_ Mom's Cell #: \_\_\_\_\_ Dad's Cell #: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 How would you prefer us to contact you for confirming your child's appointment? \_\_\_\_\_  
 Whom may we thank for referring you:  Individual  Yellow Pages  Website  Other Marketing

### PARENT'S INFORMATION

Father  Stepfather  Guardian  
 Name: \_\_\_\_\_  
 Address (if different than above): \_\_\_\_\_  
 Home # (if different than above): \_\_\_\_\_  
 Work #: \_\_\_\_\_ Ext: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Insurance Co: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Claims Address: \_\_\_\_\_  
 Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

### PARENT'S INFORMATION

Mother  Stepmother  Guardian  
 Name: \_\_\_\_\_  
 Address (if different than above): \_\_\_\_\_  
 Home # (if different than above): \_\_\_\_\_  
 Work #: \_\_\_\_\_ Ext: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Insurance Co: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Claims Address: \_\_\_\_\_  
 Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

### EMERGENCY CONTACT

In the event of an emergency, whom should we contact?  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

### DENTAL HISTORY

Date of last dental visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Cleaning/Fluoride: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last X-Rays: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Dentist's Name: \_\_\_\_\_  
 My child brushes his/her teeth \_\_\_\_ (#) of times during the day.  
 Do you ever help your child brush his/her teeth? (Please circle) Always Sometimes Never  
 Does your child floss every day?  Yes  No Is fluoride taken in any form?  Yes  No  
 Any unhappy dental experiences?  Yes  No Any injuries to the mouth/teeth/head?  Yes  No  
 Has your child complained about dental problems?  Yes  No  
 Does your child have any mouth habits? (please circle one or more)  
 Thumb sucking Nail Biting Mouth Breathing Pacifier Sleeping with bottle Other: \_\_\_\_\_

## MEDICAL HISTORY

Child's Physician: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone#: \_\_\_\_\_

Date of last physical exam: \_\_\_/\_\_\_/\_\_\_

Has he/she been hospitalized?  Yes  No If so, why?: \_\_\_\_\_

Has he/she had surgery?  Yes  No Please List: \_\_\_\_\_

Any handicaps/disabilities?  Yes  No Please List: \_\_\_\_\_

Place a mark on "yes" or "no" if your child has had any of the following:

ADD/ADHD  Yes  No

Headaches  Yes  No

AIDS/HIV  Yes  No

Mumps  Yes  No

Anemia  Yes  No

Heart Murmur  Yes  No

Asthma  Yes  No

Hepatitis  Yes  No

Artificial Heart Valve  Yes  No

Hemophilia  Yes  No

Autism  Yes  No

Kidney/Liver Disease  Yes  No

Bladder Problems  Yes  No

Learning Disability  Yes  No

Bleeding Problems  Yes  No

Measles  Yes  No

Cancer/Tumors  Yes  No

Mental Problems  Yes  No

Cerebral Palsy  Yes  No

Mononucleosis  Yes  No

Hearing Impairment  Yes  No

Rheumatic Fever  Yes  No

Chicken Pox  Yes  No

Scarlet Fever  Yes  No

Congenital Heart Disease  Yes  No

Sickle Cell Disease  Yes  No

Convulsions/Seizures  Yes  No

Sinus Problems  Yes  No

Diabetes  Yes  No

Thyroid Disease  Yes  No

Drug/Alcohol Abuse  Yes  No

Tuberculosis  Yes  No

Epilepsy  Yes  No

Other: \_\_\_\_\_

Fainting  Yes  No

Girls: Are you pregnant?  Yes  No Taking Birth Control Pills?  Yes  No Nursing?  Yes  No

### MEDICATIONS

Please list any medications your child is currently taking and the correlating diagnosis:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

None

### Allergies

Aspirin

Iodine

Penicillin

Local Anesthetic

Sulfa

Latex

Other (Please List): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### HEALTH HISTORY UPDATE

Date: \_\_\_\_\_ Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Current Health Conditions: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Staff: \_\_\_\_\_

Date: \_\_\_\_\_ Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Current Health Conditions: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Staff: \_\_\_\_\_

Date: \_\_\_\_\_ Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Current Health Conditions: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Staff: \_\_\_\_\_

Date: \_\_\_\_\_ Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Current Health Conditions: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Staff: \_\_\_\_\_

## CONSENT FOR TREATMENT

The information that I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Turner and/or associates to perform the necessary dental procedures including, but not limited to, the use of Nitrous Oxide (laughing gas), Local Anesthetic (like Lidocaine), and any necessary x-rays needed on my child.

ALL PROCEDURES WILL BE DISCUSSED WITH YOU PRIOR TO ANY DENTAL TREATMENT.

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL INFORMATION

- Our policy requires payment in full at the time of service. Insurance reimbursement for covered services is subject to maximum allowable fees, deductibles, and co-payments. Your responsibility is estimated and due at the time of treatment. It is also your responsibility as parent/guardian to pay any remaining balance on your account after any and all insurance benefits have been collected.
- If your account is not paid within 90 days, you will be liable for all collection fees, legal and court fees, interest charges, and any other expenses incurred while collecting your account.
- I hereby authorize all insurance benefits, if any, to be assigned directly to Jason E. Turner, DMD, otherwise payable to me for services rendered. I authorize the release of any information required to process insurance claims, including the use of my signature on all insurance submissions.

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## OTHER OFFICE POLICIES

- If you are unable to keep an appointment, please notify our office within 24 hours. We are dedicated to providing our patients with timely scheduling. Please do not skip appointments or avoid calling to reschedule if needed. This will help ensure other deserving patients may be able to be scheduled in your original appointment time.
- There may be a \$50 fee charged to your account for all appointments that are cancelled and/or broken within less than 24 hours.
- After having 3 missed or broken appointments, we will no longer be able to provide your child with dental care. If this happens, you will be notified by mail of your child's dismissal from our practice. We will continue to provide emergency dental care for your child for up to 30 days following the dismissal.
- We will be unable to reschedule your child's first new patient visit if you do not show up for that visit or do not notify us of the cancellation within 24 hours prior to that visit.
- In general, we use white (resin) material for fillings. Often there is a difference in benefits to be paid by insurance companies between these fillings and "silver" fillings. It is your responsibility to let our office know if you would prefer a silver filling for your child due to insurance.

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_