CHILD FORM

Pine Ridge Dental

Pine Ridge Dental
5140 S. 56th St. Lincoln, NE 68516 ● 8545 Executive Woods Dr. Lincoln, NE 68512
Phone: 402.423.1100 ● Fax: 402.423.1368 ● www.pineridgedental.com

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.
Please fill out these forms completely. The better we communicate, the better we can care for you.

Child's name:_____ Today's Date:_____

Name preference:_____ ☐ Male ☐ Female

Referred to Pine Ridge Dental through:_____

Birthdate:_____ Age:_____ SSN:_____

Home Address:_____
Street City State Zip

Person responsible for child's account:_____ Relationship:_____

Billing Address (if different):_____
Street City State Zip

Primary Contact:_____ Relationship:_____ Phone:_____
☐ Call ☐ Text

E-mail: _____

Secondary Contact:_____ Relationship:_____ Phone:_____
☐ Call ☐ Text

Emergency Contact:_____ Relationship:_____ Phone:_____

Medical Information

Physician's Name:_____ Phone: _____

Date of last physical exam:_____

Is your child currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

_____

Is your child currently taking any medications?
☐ Yes ☐ No If yes, please list or attach on a separate sheet

_____

_____

_____

For teens, are you pregnant? ☐ Possibly ☐ Yes ☐ No If yes, week#: __

Does your child need to be pre-medicated with antibiotics before dental treatment? ☐ Yes ☐ No
If yes, what is the Pre-Med for? _____

Has your child had serious medical problems? ☐ Yes ☐ No
If yes please explain _____

_____

Check box if you have had any history of or conditions related to, any of the following:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma/Respiratory problems
- ☐ Bladder
- ☐ Cancer/Tumors
- ☐ Cerebral Palsy
- ☐ Chicken pox
- ☐ Chronic sinus problems
- ☐ Chronic Hepatitis
- ☐ Chemo/Radiation
- ☐ Diabetes
- ☐ Drug/Alcohol abuse
- ☐ Dental Anxiety
- ☐ Epilepsy/Seizures
- ☐ Fainting spells
- ☐ Fever blister/cold sores
- ☐ Growth problems
- ☐ Hearing problems
- ☐ Heart
- ☐ Hemophilia /bleeding
- ☐ HIV+/AIDS
- ☐ Human papilloma virus
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Psychiatric disorders
- ☐ Sickle cell disease
- ☐ Sight problems
- ☐ Tobacco use, how much?__
- ☐ Transplant
- ☐ Tuberculosis
- ☐ **NONE**

Has your child experienced any other conditions that are not listed above? ☐ Yes ☐ No If yes, please list: _____

_____

_____

Allergies:

- ☐Penicillin/Amoxicillin
- ☐Aspirin
- ☐Sulfa drugs
- ☐Jewelry/Nickel
- ☐Erythromycin
- ☐Tetracycline
- ☐Cephalosporins
- ☐Latex (rubber)
- ☐Sulfur drugs
- ☐Dental anesthetics
- ☐Codeine
- ☐Clindamycin
- ☐Other, please list

Is your child allergic to any medications or products not listed above?

☐ Yes ☐ No If yes, please list _____

_____

_____

Dental Information

Why have you come to the dentist today?

_____

_____

If this is not your first visit, when were your child's teeth last cleaned? _____

Has your child had complication or difficulties with previous dental treatment? ☐ Yes ☐ No If yes please explain: _____

_____

_____

What type of water do you drink? (check all that apply)
☐ City ☐ Well ☐ Bottled ☐ Filtered

Does your child participate in physical recreational activities?
☐ Yes ☐ No

If you have dental insurance, do you let the insurance dictate what treatment your child should receive? ☐ Yes ☐ No

Do you have suggestions on how Pine Ridge Dental can best meet your needs? ☐ Yes ☐ No If yes please explain: _____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

Patient signature:_____ Date:_____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY Doctor's Comments:

_____

_____

_____