GIVING TREE PEDIATRIC DENTISTRY

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We are thrilled to welcome you and your family and look forward to working with you to maintain your child's oral health. **Please fill out this form as completely as possible.** If you have any questions, we will be happy to help.

Tell Us About Your Child

Child's Name _____, M ☐ F ☐

Last first MI

Nickname_____ Child's Birthdate _____/_____/_____ Age _____

Address_____ City _____ State _____ Zip_____

Child's Favorite Activity/Music/TV Show/Video Game _____

_____

Does Your Child Play Sports? ☐ Yes ☐ No If Yes, What Sports_____

Names and ages of Siblings _____

_____

How Did you Hear About the Office? (please list name)

☐ Pediatrician/Other Dentist_____ ☐ Friend _____

☐ School/Church/Synagogue _____ ☐ Insurance Company

☐ Google ☐ Yelp ☐ Local Newspaper ☐ Other

Parent Information

Parent 1

Name _____ DOB:_____ Occupation _____ SS# _____

Employer (name/address) _____

Work Phone _____ Home Phone _____ Cell Phone _____

Email address _____ Preferred Method of Contact _____

Parent 2

Name _____DOB:_____ Occupation _____ SS# _____

Employer (name/address) _____

Work Phone _____ Home Phone _____ Cell Phone _____

Email address _____ Preferred Method of Contact _____

Who is accompanying the child today?

Name _____ Relationship _____

Authorized Nanny/Sitter/ Au Pair _____

In the event that I am unable to bring my child in for an appointment the following individuals have my permission to accompany my child and make any necessary decisions for my child's care. This includes consenting to any necessary treatment plan changes.

Name: Relationship Contact Number

_____

_____

_____

The legal guardian must accompany their child/children for the first appointment.

Insurance/Financial Information

Name of Dental Insurance Company _____

Telephone # of Insurance Company _____

Policy Holder ID # _____ Group # _____

Annual Deductible Amount _____ Annual Maximum _____

*Most insurance reimburses 100% for preventative treatment and 50-80% for restorative and other advanced procedures. Please contact your insurance carrier directly for specifics.

*First time patients, please bring your dental insurance card to the office or email copies of both sides in advance of the first appointment.

Dental History

Reason for Today's Visit _____

Is this your Child's first visit to the dentist? ☐ Yes ☐ No

If not, who was the previous dentist _____ Phone # _____

When was your child's last exam? ___/___/____ when were x-rays taken? ___/___/____

If x-rays were taken, please ask previous office to email your child's records to giving treedental@gmail.com

Previous Dental Injury? ___/___/____

Does your child require pre-medication prior to dental treatment? ☐ Yes ☐ No

Has Your Child had a history of the following and if so when did they stop:

☐ Bedtime Bottle ☐ Fluoride Vitamins ☐ Pacifier ☐ Breast feeding

☐ Iron Supplements ☐ Teeth grinding ☐ Bottled water ☐ Mouth breathing

☐ Snoring ☐ Thumb sucking ☐ Finger sucking ☐ Fingernail biting ☐ Sleep Apnea

☐ Non-fluoridated water ☐ Other Habit _____ Age stopped _____

What Kind of multivitamin does your child use, if any?

☐ Chewable ☐ Liquid Drops ☐ Gummy ☐ None

Does your child take a fluoride supplement prescribed by pediatrician or previous dentist?

☐ Yes ☐ No

Do you brush your child's teeth, or do they brush independently? _____

Does your child use: ☐ Floss/Flossers ☐ Fluoride Rinse (i.e. ACT) ☐ None*

*no worries we are here to teach your child the importance of flossing when indicated

Child's Temperament

☐ Shy ☐ fearful ☐ Requires Special understanding ☐ Easygoing ☐ Calm ☐ Outgoing

How do you think your child will act during dental treatment? _____

How has your child's experience with other doctors been? _____

Has your child had any previous negative dental experiences, if yes please explain _____

_____

Please list any additional questions or concerns you may have?

_____

Health History

Your Child's health is ☐ Excellent ☐ Fair ☐ Poor

Child's Physician _____ Phone # _____

Date of last physical exam ___/___/____

Ever been hospitalized overnight? ☐ Yes ☐ No When? _____ Reason _____

Vaccinations up to date? ☐ Yes ☐ No*

*Giving Tree Dental is unable to accommodate patients who are not immunized. Our numerous patients with cancer history experience a severe immunocompromised status. Please speak with the doctor with any questions and they will be happy to speak with you.

History of Surgery? ☐ Yes ☐ No Type of Surgery _____

Does your child have any allergies (food/medications)? ☐ Yes ☐ No

If yes, please list _____

_____

Has your child ever had any of the following conditions?

☐ Artificial bones/Joints	☐ Artificial Heart Valve	☐ Asthma	☐ Arrhythmia
☐ Autistic Spectrum Disorder	☐ Abnormal Bleeding	☐ ADHD	☐ Anemia
☐ Blood Transfusion	☐ Cancer/Tumors	☐ Birth Defects	
☐ Cleft Lip/Palate	☐ Crohn's Disease	☐ Congenital Heart Defect	
☐ Cerebral Palsy	☐ Developmental Delay	☐ Diabetes	
☐ Recurrent Ear Infections	☐ Hearing Loss	☐ Endocrine Function Issue	
☐ Epilepsy/Seizures	☐ Eye/Vision Problems	☐ Fainting/Dizziness	
☐ Glaucoma	☐ Gluten/Celiac Disease	☐ Glucose 6 Phos. Dehy. Def.	
☐ Heart Murmur	☐ Hemophilia	☐ High/Low Blood Pressure	
☐ HIV/AIDS	☐ Kidney Disease	☐ Liver/ Hepatitis	
☐ Jaw Problems TMJ/TMD	☐ Jaundice	☐ Leukemia	
☐ Lung Disease	☐ Lymphoma	☐ Metabolic Disorder	
☐ Malignant Hyperthermia (or Family History)		☐ Milk Sensitivity (Casein/Lactose)	
☐ Psychiatric Issues	☐ Rheumatic Fever	☐ Scarlet Fever	

☐ Speech Issues ☐ Sickle Cell ☐ Tuberculosis

☐ Thyroid Function Issue ☐ Tonsillitis ☐ Ulcerative Colitis

☐ ODD/OCD ☐ Other not listed _____

_____

Please List ALL medications and dosages your child takes

_____

_____

_____

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence.

It is my responsibility to update the office of any changes to my child's medical status and current medications.

I am the parent, guardian, or personal representative of this child. There are no court orders in effect that prohibit me from signing consent for this child. I do herby request and authorize the staff at Giving Tree Pediatric Dentistry to preform necessary dental services for the child named in this document, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is completed.

I understand and agree that Dr. Tannen will make a courtesy evaluation of emergencies via cellular phone photos, should I (the parent/guardian) request this. I agree that communication may be made via secure email conversations between the doctor and myself (parent/guardian). Giving Tree Pediatric Dentistry will maintain the strictest measures to protect my family's privacy.

Parent/Guardian's Signature _____ Date _____

Parent/Guardian Name Printed _____