

# DOUGLAS S FRY, DDS PEDIATRIC DENTISTRY

## **New Patient Information:**

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SSN: \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_  
Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Physician's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## **Parent/Guardian Information:**

Parent/Legal Guardian: \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
Email: \_\_\_\_\_  
How would you like to receive appointment reminders: phone \_\_\_ email \_\_\_ both \_\_\_?  
Parent/Legal Guardian: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
Email: \_\_\_\_\_  
With whom does the child reside? \_\_\_\_\_

## **Insurance Information:**

### *Primary Insurance Coverage*

Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
Carrier: \_\_\_\_\_ Subscriber#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Provider Benefits and Claims Department Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## **Emergency Contact Information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## **Referral Source:**

### **Child's Dental History:**

Please tell us the reason for your child's dental visit: \_\_\_\_\_  
Has your child ever visited a dentist before? YES \_\_\_ NO \_\_\_  
- Name of previous dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
- Date of last cleaning? \_\_\_\_\_ were x-rays taken? YES \_\_\_ NO \_\_\_  
Has your child experienced any unfavorable reaction from previous dental care?  
- If yes, please explain: \_\_\_\_\_  
Has your child ever had an adverse reaction to local anesthetic, nitrous oxide sedation, oral sedation or general anesthesia? \_\_\_\_\_  
Does your child have an oral habit?  
- (Please check): THUMB \_\_\_ FINGER \_\_\_ PACIFIER \_\_\_ OTHER \_\_\_\_\_  
Do you have concerns about how your child's teeth fit together (crooked/crowded?) YES \_\_\_ NO \_\_\_  
Does your child go to bed with a bottle or sippy cup? YES \_\_\_ NO \_\_\_  
Does your child snack frequently? YES \_\_\_ NO \_\_\_  
Is your home water supply fluoridated? YES \_\_\_ NO \_\_\_ UNKNOWN \_\_\_  
Do you still help your child brush and floss? YES \_\_\_ NO \_\_\_  
Is your child experiencing dental pain/infections? YES \_\_\_ NO \_\_\_  
Has your child experienced dental trauma? YES \_\_\_ NO \_\_\_ Please explain: \_\_\_\_\_  
Is there anything we should know about your child that would make his/her experience more enjoyable?

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## Child's Medical History:

Is your child in good health? YES \_\_\_ NO \_\_\_ Date of last exam: \_\_\_\_\_

Has your child ever been hospitalized? YES \_\_\_ NO \_\_\_ Please explain: \_\_\_\_\_

Does your child have any allergies? YES \_\_\_ NO \_\_\_ Type: \_\_\_\_\_

Is your child currently taking any medications?

- Please list medication/dose/reason: \_\_\_\_\_

Are your child's immunizations current? YES \_\_\_ NO \_\_\_

Has your child been told to take antibiotics before dental treatment? YES \_\_\_ NO \_\_\_

Were there any complications at your child's birth? YES \_\_\_ NO \_\_\_

- Please explain: \_\_\_\_\_

Do you consider your child to be (please check one)?

\_\_\_Advanced in the learning process \_\_\_Progressing normally \_\_\_Slow in the learning process

## Please check if your child has been treated for any of the following:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Bleeding/Transfusions   |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Blood Problems            | <input type="checkbox"/> Tonsil/Adenoid Problems |
| <input type="checkbox"/> Liver/GI Disease     | <input type="checkbox"/> Sickle Cell Disease/Trait | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Rheumatic fever           | <input type="checkbox"/> Hepatitis               |
| <input type="checkbox"/> Speech/Hearing       | <input type="checkbox"/> Seizures                  | <input type="checkbox"/> Cleft Lip/Palate        |
| <input type="checkbox"/> Eyesight             | <input type="checkbox"/> Congenital Birth Defects  | <input type="checkbox"/> Mental Health           |
| <input type="checkbox"/> Recurrent Headaches  | <input type="checkbox"/> Hormone/Growth Problems   | <input type="checkbox"/> adverse drug reactions  |
| <input type="checkbox"/> Significant Injuries | <input type="checkbox"/> Frequent Ear Infections   | <input type="checkbox"/> Autism                  |
| <input type="checkbox"/> ADHD/ADD             | <input type="checkbox"/> Spina Bifida              | <input type="checkbox"/> Asthma/breathing        |
| <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> HIV/AIDS                  | <input type="checkbox"/> Mental Delays           |
| <input type="checkbox"/> Physical Delays      | <input type="checkbox"/> Cancer/tumors             | <input type="checkbox"/> Cerebral Palsy          |

OTHER: \_\_\_\_\_

Please take a moment to explain any conditions checked above: \_\_\_\_\_

## Consent for Dental Treatment

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize Dr. Fry and their staff to perform any necessary dental services including but not limited to a comprehensive examination, cleanings, fluoride treatment, any necessary dental treatment for my child's teeth, x-rays as necessary to diagnose and/or treat my child's dental problem, and administration of anesthetics that are deemed advisable by Dr. Fry, whether or not I am present when the treatment is rendered. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Fry will provide an environment that will help your child cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones.

I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Dr. Fry of any changes in my child's medical status.

Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Notes and Attestation: \_\_\_\_\_

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