



WELCOME!

Thank you for choosing Cherry Creek Pediatric Dentistry for your child's dental care!

PATIENT INFORMATION

Name: _____ Nickname: _____ DOB: _____ Gender: M F
Street Address: _____ City: _____ State: _____ Zip: _____
Primary number for appointment confirmations: () - _____
Who is accompanying the child today?
Name: _____ Relation: Father Mother Foster Nanny Other: _____
Is your child a ward of the state? : Yes No If yes, case worker's contact information: _____

PARENT INFORMATION

Who does the patient live with? : Guardian 1 & 2 Guardian 1 Guardian 2 Other: _____

GUARDIAN (I)

Name: _____ Gender: M F
DOB: _____ SS#: _____
Marital Status: Single Married Domestic Partnership
 Separated Divorced Widowed
Home: () - _____ Cell: () - _____
Email: _____
 Check box if Address is same as patient's listed above.
Street Address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Work: () - _____

GUARDIAN (II)

Name: _____ Gender: M F
DOB: _____ SS#: _____
Marital Status: Single Married Domestic Partnership
 Separated Divorced Widowed
Home: () - _____ Cell: () - _____
Email: _____
 Check box if Address is same as patient's listed above.
Street Address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Work: () - _____

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

Name of Insured: _____
DOB: _____ SS#: _____
Employer: _____
Phone: () - _____
Insurance Co.: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: () - _____
Group/Policy #: _____
I.D. #: _____

SECONDARY COVERAGE

Name of Insured: _____
DOB: _____ SS#: _____
Employer: _____
Phone: () - _____
Insurance Co.: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: () - _____
Group or Policy #: _____
I.D. #: _____

REFERRAL INFORMATION

Sibling(s): _____
 Friend: _____
 Pediatrician/Physician: _____
 Dentist/Dental Office: _____
 Insurance: _____
 School/Daycare: _____
 Community Event: _____
 Google
 Website
 Facebook
 Angie's List
 Print Ad (magazine, newspaper, etc): _____
 Media Ad (radio, movie theater, etc.): _____
 Other: _____

DENTAL HISTORY

DENTAL CONCERNS

What is the primary reason for today's visit? : Cleaning Trauma/Dental Emergency Consult for Decay

Has your child ever been to the dentist? : Yes No

(If Yes) Previous/Present Dentist: _____ Date Last Exam: _____ Date Last X-Rays: _____

Do you think your child will react well to treatment? : Yes No

Please describe any tips/tricks that will help our team provide a positive experience for your child's visit: _____

DENTAL HABITS

Does your child currently... (check all that apply)

- Suck Thumb/Finger Suck/Bite Lips Bite/Chew Nails Tongue Thrust Bottle Feed
 Use Pacifier Tongue/Cheek Chew Clench/Grind Teeth Mouth Breather Breast Feed

HYGIENE ROUTINE

(check all that apply)

- Fluoride Toothpaste Consume Fluoridated Water Brushing by Child: ____/day Snack between Meals - Type of snacks: _____
 Fluoride Mouthwash Dental Floss: ____/week Brushing by Parent: ____/day _____

MEDICAL HISTORY

Are immunizations current? : Yes No

Child's Physician: _____ Phone: () - _____ Date Last Exam: _____

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain): _____

Current Medications: _____

Is your child followed by a specialist? : Yes No If yes, provide name & contact information: _____

Has your child been diagnosed and/or treated for any of the following... (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Blood Disorder/Anemia | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Other Condition (specify): _____ |
| <input type="checkbox"/> Abnormal Bleeding/Hemophilia | <input type="checkbox"/> Asthma/Reactive Airway | _____ |
| <input type="checkbox"/> Immune Disorder/HIV/AIDS | <input type="checkbox"/> Tonsillitis | |
| <input type="checkbox"/> Cancer/Tumor/Leukemia | <input type="checkbox"/> Congenital Birth Defects | |
| <input type="checkbox"/> Heart Murmur/Defect/Surgery | <input type="checkbox"/> Premature/Low Birth Weight | |
| <input type="checkbox"/> Epilepsy/Seizures/Convulsions | <input type="checkbox"/> Cleft Lip/Palate | |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Autism Spectrum | |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> ADD/ADHD | |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Eating Disorder | |
| <input type="checkbox"/> Liver Disease/Jaundice/Hepatitis | <input type="checkbox"/> Speech Disorder | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Vision Problems | |
| <input type="checkbox"/> Sickle Cell Trait | <input type="checkbox"/> Hearing Problems | |
| <input type="checkbox"/> Stomach/GI Disorders | <input type="checkbox"/> Deaf | |
| | <input type="checkbox"/> Mental/Cognitive/Social Delay | |

ALLERGIES:

- Drug: _____
 Food: _____
 Seasonal
 Hives
 Latex
 Other (specify): _____

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand that Cherry Creek Pediatric Dentistry may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Cherry Creek Pediatric Dentistry all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.

Guardian Signature: _____ Date: _____