Anne Lindley, DDS

Dentistry for Children and Teens

Today's Date: _____

TELL US ABOUT YOUR CHILD

Child's Name: _____
Last First MI

Nickname: _____ ☐ Male ☐ Female

Siblings that we treat: _____

Child's Birthdate: ____ / ____ / ____ Child's Age: _____

Child's Home Phone #: (_____) _____

Child's Home Address: _____

_____
City State Zip

School: _____ Grade: _____

Who may we thank for referring you to our office?

_____

MOTHER'S INFORMATION

Name: _____

Mother Stepmother Guardian Birthdate: ____/____/____

Employer: _____

Cell Phone #: (_____) _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext. _____

SS#: _____ DL#: _____

Marital Status: ☐ Single ☐ Married ☐ Separated
☐ Widowed ☐ Divorced

FATHER'S INFORMATION

Name: _____

Father Stepfather Guardian Birthdate: ____/____/____

Employer: _____

Cell Phone #: (_____) _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext. _____

SS#: _____ DL#: _____

Marital Status: ☐ Single ☐ Married ☐ Separated
☐ Widowed ☐ Divorced

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Relationship: _____

Billing Address: _____

_____
City State Zip

Cell Phone #: (_____) _____

Work Phone #: (_____) _____ Ext. _____

Email: _____

PRIMARY DENTAL INSURANCE

Dr. Lindley is not a contracted dentist with any dental insurance company. Our practice is considered an **out of network provider (PPO)**. Any charges not paid by your insurance company are your responsibility and due on receipt of your statement or at the time of service. To get the best possible benefit from your insurance, please provide the proper dental information that is available on your card. We don't accept assignment of benefits on secondary insurance.

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____ / ____ / ____

Social Security #: _____

Policy Owner's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____ / ____ / ____

Social Security #: _____

Policy Owner's Employer: _____

Today's Date: _____

DENTAL HISTORY

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

If not, how long since last visit to the dentist? _____

Previous Dentist's Name: _____

Any x-rays taken at previous dental visit? ☐ Yes ☐ No

Have there been any injuries to the teeth, face, or mouth? ☐ Yes ☐ No

If yes, please explain: _____

_____

Why did you bring the child to the dentist today?

_____

Does the child have any of the following habits?

Y N Lip Sucking/Biting **Y N** Nail Biting

Y N Nursing/Bottle Habits **Y N** Thumb/Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? ☐ Yes ☐ No

If yes, please explain: _____

_____

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoride supplements? ☐ Yes ☐ No

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Does the child floss his/her teeth daily? ☐ Yes ☐ No

SOCIAL MEDIA

We would love to share how great your child is doing with our fans on our Social Media and need your approval to do so. Please check the appropriate boxes below with any preferences:

☐ Name & Picture ☐ Picture Only

☐ First Name Only & Picture ☐ No Picture or Name

HEALTH HISTORY

Has the child ever had any of the following conditions?

Y N Disabilities/Special Needs
Y N Hearing/Vision Impaired
Y N Heart Disease/Murmur
Y N Hemophilia/Blood Disorders
Y N Mental Health Issues
Y N HIV+/AIDS/Hepatitis
Y N Kidney/Liver Conditions
Y N Congenital Birth Defects
Y N Developmental Delay
Y N Convulsions/Epilepsy
Y N Sleep Apnea/Heavy Snoring

Y N ADD/ADHD
Y N Allergies to Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Diabetes
Y N Pregnancy
Y N Tuberculosis
Y N Autism
Y N Allergies to Latex

Please discuss any serious medical conditions the child has had: _____

_____

Please list any drugs the child is currently taking:

_____

Please list any allergies: _____

_____

Child's Physician: _____

Physician's Phone #: (_____) _____

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

Please describe the child's physical health:

Good Fair Poor

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

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: _____

Relationship: _____

Do you have legal custody of this child? ☐ Yes ☐ No

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ Date: _____