

RACHEL PACKER, DDS, PC
PEDIATRIC DENTISTRY

PATIENT HEALTH INFORMATION

Patient's Full Name _____

Prefers to be called _____ Age _____ Weight _____

Pediatrician's Name _____ Phone _____

	Yes	No	
Does child have a health problem?	()	()	_____
Is child under care of physician now?	()	()	_____
Does child bleed excessively when cut?	()	()	_____
Has child ever had any emotional, mental, or nervous problems?	()	()	_____
Has child experienced any unfavorable reactions to any drugs? .	()	()	_____

Please list the following:

Regular medications being taken by child _____

Medicines or drugs to which child is allergic _____

Any other allergies _____

Previous hospitalizations _____

Has child had any history or difficulty with the following? If so, please check (✓)

_____ Anemia	_____ Cleft Lip or Palate	_____ Hearing	_____ Malignancy
_____ Asthma	_____ Convulsions	_____ Heart	_____ Measles
_____ Bladder	_____ Diabetes	_____ Hepatitis	_____ Mononucleosis
_____ Cancer	_____ Epilepsy	_____ HIV Positive / Aids	_____ Mumps
_____ Cerebral Palsy	_____ Exposed to HIV, but Neg.	_____ Kidney	_____ Pregnant
_____ Chicken Pox	_____ Fainting	_____ Liver	_____ Rheumatic Fever
_____ Chronic Sinusitis		_____ Lungs	_____ Speech Problems
			_____ Tuberculosis

Yes No

Has child ever had a local anesthetic? () () _____

Has child had any unfavorable dental experiences? () () _____

Has child had any injuries to the mouth or teeth? . () () _____

Does child have a toothache now? () () _____

Has child recently had a toothache? () () _____

Does child have any of the following habits? (please circle) thumbsucking, nail biting, mouth breathing.

Date of child's most recent dental exam _____, dental x-rays _____, fluoride treatment _____

Reason for today's visit _____

Please identify any dental or medical problem of special concern or provide any other information which you think might be important in the care of your child. _____

CONSENT FOR A TREATMENT OF A MINOR

The undersigned hereby authorizes Rachel L. Packer, DDS and Dental Staff to perform the examination (including any necessary X-rays) and, after explanation, all forms of treatment, medication, and therapy indicated for the dental care of the above named child. This consent shall remain in full force and effect until cancelled by either party.

Signature _____ Relationship to Child _____ Date _____

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

OVER

Patient Information

A B C

Today's Date _____ Acct. # _____

First Name: _____ Last Name: _____ Middle: _____

Nickname _____ male female Birthdate ____/____/____

SS#: _____ Age: _____ Grade _____ Hobbies: _____

Address: _____ Home Phone: () _____

City _____ State _____ Zip _____

Other children:	Name	Birthdate	Age
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____

Whom may we thank for referring you? _____

Responsible Party Information

Parent Information

Colorado Law states custodial parent is responsible for account.

Person accompanying patient today? Mother Father Other _____ Name _____

Do you have legal custody of patient? yes no

Parents Marital Status (please check) Single Widowed Married Remarried Divorced Separated

Father's Information: (please check) Father Step Father Guardian Other

First Name _____ Last _____ MI _____ Birthdate ____/____/____

Social Sec. # _____ Employer _____

No. years employed _____ Occupation _____ Wk. Phone _____

Mother's Information: (please check) Mother Step Mother Guardian Other

First Name _____ Last _____ MI _____ Birthdate ____/____/____

Social Sec. # _____ Employer _____

No. years employed _____ Occupation _____ Wk. Phone _____

Custodial Parent:

Name _____ Relation _____ Hm. Phone _____

Address _____ City _____ State _____ Zip _____

How long at this address ? _____

Previous Address _____ City _____ State _____ Zip _____

(If less than three years)

Insurance Information

Primary Insurance:

Insured's Name _____

Relationship to Patient _____

Insured's Birthdate ____/____/____

Social Sec. # _____

Insured's Employer _____

Insurance Co. Name _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Co. Phone () _____

Group # (Plan Local, or Policy #) _____

Orthodontic Coverage Yes No

Secondary Insurance:

Insured's Name _____

Relationship to Patient _____

Insured's Birthdate ____/____/____

Social Sec. # _____

Insured's Employer _____

Insurance Co. Name _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Co. Phone () _____

Group # (Plan Local, or Policy #) _____

Orthodontic Coverage Yes No

Emergency Information

Name of nearest relative not living with you _____

Address _____ City _____ State _____ Zip _____

Phone # () _____ Relationship _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

OVER

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