



Paducah Pediatric Dentistry

J. D. Johnston, D.D.S., M.S.

Child's Name _____ Age _____ Birthdate _____ Sex F M

Name child goes by _____ Place of Birth _____

Child's Home Address _____

City _____ State _____ Zip _____ Phone _____

Child's Social Security # _____

Have we previously seen other family members? Yes No Names _____

Do parents live together? Yes No If no, with whom does the child live? _____

Who has legal custody of this child? _____ Parent or Guardian Email Address _____

PARENT OR GUARDIAN INFORMATION Mother Stepmother Guardian

Name _____ Date of Birth _____ Occupation _____

Home Address _____ Home Phone # _____

Employer _____ SS# _____ Work Phone # _____ Cell Phone # _____

PARENT OR GUARDIAN INFORMATION Father Stepfather Guardian

Name _____ Date of Birth _____ Occupation _____

Home Address _____ Home Phone # _____

Employer _____ SS# _____ Work Phone # _____ Cell Phone # _____

How did you hear about our office? _____

Who is your family dentist? _____

METHOD OF PAYMENT

Cash or Check at time of treatment MasterCard Visa CareCredit Financing
(ask a staff member for details)

Insurance – Plus co-payment at time of treatment

Kentucky Medicaid # _____

PRIMARY DENTAL INSURANCE

Insured's Name _____ Relationship to patient _____

Birthdate _____ Social Security # _____

Employer _____

Insurance Co. _____ Group # _____

Insurance Co. Address _____

Insurance Co. Phone # _____

FINANCIAL POLICY

Fees for dental services rendered are due on the date of treatment. Our office, as a courtesy to you, will file for insurance benefits for treatment rendered. At your first visit we request that the balance be paid **in full**. On subsequent visits, you will be responsible for any **deductibles, co-payments, or balances not covered by your insurance**. All account balances which have not been paid within 30 days becomes the responsibility of the parent/guardian. There will be a \$25.00 charge on all returned checks.

CHILD'S HEALTH HISTORY

Name of Child's Physician _____ Physician's Phone # _____

Date of Child's last Medical Examination _____ Results _____

Yes No (Please check yes or no)

Is your child being treated by a physician at this time? Reason _____

Is your child presently taking any medications? Names _____

Has your child ever been hospitalized? Reason _____

Is your child allergic to any medication (Drugs)? List _____

Has the child ever had any of the following:

Yes No

- | | | |
|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Hyperactivity / A.D.D. / A.D.H.D. | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> <input type="checkbox"/> A.I.D.S. / H.I.V. Positive | <input type="checkbox"/> <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> <input type="checkbox"/> Allergy | <input type="checkbox"/> <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Eye, Ear, Nose, Throat Problems | <input type="checkbox"/> <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding / Hemophilia | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> <input type="checkbox"/> Autism | <input type="checkbox"/> <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> <input type="checkbox"/> Shunt |
| <input type="checkbox"/> <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> <input type="checkbox"/> Heart Condition | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Anemia / Trait |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> <input type="checkbox"/> Blood / Circulatory Problems | <input type="checkbox"/> <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> <input type="checkbox"/> Speech Disorder |
| <input type="checkbox"/> <input type="checkbox"/> Brain Injury | <input type="checkbox"/> <input type="checkbox"/> Kidney / Bladder Problems | <input type="checkbox"/> <input type="checkbox"/> Syndrome _____ |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> <input type="checkbox"/> Tonsillectomy / Adenoidectomy |
| <input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> <input type="checkbox"/> Learning or School Related Problems | <input type="checkbox"/> <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> Liver Problems | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Cleft Lip or Palate | <input type="checkbox"/> <input type="checkbox"/> Lung Problems | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease |
| | | <input type="checkbox"/> <input type="checkbox"/> Other _____ |

Yes No DENTAL HISTORY

- Any mouth habits: Thumbsucking, fingersucking, lip or nail biting, mouth breathing, pacifier, etc.?
- Any unfavorable experience from previous dental treatment or medical treatment?
- Has your child had any toothaches lately? Area _____
- Any injuries to the mouth, teeth, or head? Area _____
- Are your child's teeth brushed daily? _____ Is dental floss used? Yes No
- Do you assist with brushing? _____
- Is your water source Fluoridated? Private Well? Public System?
- Is Fluroide taken in any other form? If yes, what? _____

At what age did your child stop breast feeding? _____ Bottle Feeding? _____ Contents of Bottle? _____

Does child use sipper cup other than at meal time? Yes No How often? _____ Contents of Cup? _____

Date of child's last dental visit: _____ For what service? _____

Previous Dentist: _____

How do you think your child will react to dental treatment? _____

What is your main concern regarding your child's teeth at this time? _____

Has your child had previous dental X-rays? _____ Date _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dental staff to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services, therefore, I agree to be responsible for payment of all services rendered on my child's behalf.

Note: The custodial parent or legal guardian must accompany the child to their initial appointment.

Signature of Parent / Guardian _____ Date _____