



Interdisciplinary Dentofacial Diagnostic Systems

JEFFREY D. RHODES, D.D.S., M.S., F.A.A.P.D., P.A.

BOARD CERTIFIED PEDIATRIC DENTIST

PATIENT'S INFORMATION *(please completely fill out first and second pages)*

Patient's Full Name: _____ Name you like to be called: _____
First, Middle, Last

Patient's Address: _____ Soc. Sec. #: _____
Street, Apt. No., City, State, Zip

Home Phone: (____) _____ Date of Birth: ____/____/____ Male or Female *Circle One* Age _____

Place of Employment or School and Grade: _____ Phone: (____) _____

Person to contact in case of emergency: _____ Relationship: _____ Phone: (____) _____
(Not living in household)

Contact's Address: _____

Whom May We Thank for Referring You? _____ Name and Ages of Siblings: _____

PERSON RESPONSIBLE FOR ACCOUNT

Full Name: _____ Relation to Patient: _____
First, Middle, Last

Full Home Address: _____ Home Phone: _____
Street, Apt. No., City, State, Zip

Mobile No. _____ Pager _____ E-mail _____

If Less than 3 Years at above, Previous Address: _____ Date of Birth: ____/____/____

Marital Status: Single Married Divorced Separated Widowed Occupation: _____

Driver's License No.: _____ Social Security No.: _____ Employer: _____

Work Phone: (____) _____ Years at Employer: _____ Employer's Address: _____

Name of Spouse Other Parent: _____ Full Address: _____
First, Middle, Last

or Secondary Responsible Person:

Date of Birth: ____/____/____ Soc. Sec. #: _____ Home Phone: (____) _____ Work Phone: (____) _____

Employer: _____ Occupation (type of business): _____ Years at Employer: _____

INSURANCE INFORMATION *If you have insurance, this section must be completed*

Dental Insurance Company (name and address): _____ Phone _____

Name of Subscriber / Policy Holder: _____ Relationship to Patient: _____

Group #: _____ Identification #: _____ Other Number (s) _____

Secondary Dental Insurance Company (name and address): _____ Phone _____

Name of Subscriber / Policy Holder: _____ Relationship to Patient: _____

Group #: _____ Identification #: _____ Other Number (s) _____

Medical Insurance Company (name and address): _____ Phone _____

Name of Subscriber / Policy Holder: _____ Relationship to Patient: _____

Group #: _____ Identification #: _____ Other Number (s) _____

Secondary Medical Insurance Company (name and address): _____ Phone _____

Name of Subscriber / Policy Holder: _____ Relationship to Patient: _____

Group #: _____ Identification #: _____ Other Number (s) _____

RELEASE

I authorize the doctor or other dentists or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care.
I authorize release of any information concerning my (or my child's) health care for advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care for advice and treatment to interdisciplinary team members.
I consent to the release of credit reports and information regarding my credit history to the doctor(s). I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment, and to the use of the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature.

Date: _____ Patient or Guardian's Signature: _____

Other's Authorized to Bring Patient _____

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PATIENT NUMBER

PATIENT'S NAME _____
Last
First
Initial
Nickname
Date of Birth

PARENT'S /GUARDIAN'S NAME _____ AGE OF CHILD _____

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

COMMENTS

1. Is this your child's first visit to a dentist? YES NO
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? YES NO
4. Does your child eat between meals? YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? YES NO
6. When does your child brush his/her teeth?
 Upon Arising Right after meals Before going to bed
7. How does your child receive Fluoride?
 Community water level ___ ppm Well water level ___ ppm
 Fluoride drops or tablets Fluoride rinse or gel
8. Have any cavities been noted in the past? YES NO
9. Were any teeth (baby or permanent) removed by extraction? YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc? YES NO
 If so describe _____
11. Has your child had any problem with dental treatment in the past? YES NO
12. Has anyone in the family, including parents, had orthodontics? YES NO
13. Has your child ever received a local anesthetic? YES NO
14. Has your child ever had occlusal sealants? YES NO
15. Does your child think there is anything wrong with his/her teeth? YES NO

MEDICAL HISTORY

1. Name/Phone of family physician/ doctor _____
 Date of last exam? _____
2. Is your child receiving any medication including non-prescription? YES NO
 What? _____
3. Is your child allergic to penicillin, antibiotics or other drugs? YES NO
4. Does your child have other allergies? YES NO
5. Has your child had any serious illness? YES NO
 When _____ What _____
6. Has your child had surgery? YES NO
7. Age of last bottle use? _____

8. PLEASE TAKE TIME TO READ THE FOLLOWING CAREFULLY AND INDICATE "YES" OR "NO" FOR YOUR CHILD'S HISTORY:
- | | | |
|------------------------------------------------------|--------------------------------------------|----|
| Heart murmur or mitrovalve prolapse? YES | NO Congenital birth defects? YES | NO |
| Severe or prolonged bleeding? YES | NO Mental Retardation? YES | NO |
| Have or been tested for AIDS or HIV? YES | NO Eyesight Problems? YES | NO |
| Tested positive for Hepatitis? YES | NO Cancer? YES | NO |
| Subject to Nervous Disorders? YES | NO Speech Impairments? YES | NO |
| ___ Fainting? ___ Seizures? ___ Dizziness? | Hearing Loss? YES | NO |
| ___ ADD?ADHD? ___ Behavioral/Learning Problems | Problems w/ tonsils or adenoids? YES | NO |
| Frequent Headaches? YES | NO Stroke? YES | NO |
| Diabetes? YES | NO Shortness of breath? YES | NO |
| Asthma? YES | NO Sinus problems? YES | NO |
| Kidney or bladder infection? YES | NO Prosthetic devices? YES | NO |
| Rheumatic Fever? YES | NO Tuberculosis (TB)? YES | NO |
| Epilepsy? YES | NO Mouth-breathing or snoring? YES | NO |
| Cerebral Palsy? YES | NO Stomach problems? YES | NO |
| Liver Problems? YES | NO Thyroid problems? YES | NO |
| Arthritis? YES | NO Gag easily? YES | NO |
| High priority in keeping natural teeth? YES | NO Pregnant? YES | NO |
| Taking birth control pill? YES | NO Sexually transmitted disease? YES | NO |
| Bleeding gums? YES | NO Clenching or grinding teeth/ YES | NO |
| Sore teeth/sensitive to hot ,cold, or sweets? YES | NO Fever blisters/mouth ulcers? YES | NO |
| Suck thumb or fingers (now or past)? YES | NO Tongue thrusting habit? YES | NO |
| Drink coffee or use tobacco? YES | NO Wake up with sore jaw? YES | NO |
| Tenderness/stiffness in jaw, neck or back? YES | NO Ringing or pain in ears? YES | NO |
| Pain, popping, catching, or locking in jaw? | YES | NO |
| In treatment for or told you have gum disease? | YES | NO |

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

ANEST.

DENTIST'S SIGNATURE _____ DATE _____

MED. ALERT

CHILD DENTAL MEDICAL HISTORY