Michael A. Shannon, D.D.S., M.S., Inc.

Pediatric Dentistry

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PATIENT INFORMATION

Name _____ Nickname _____ Sex: Male / Female
First Middle Last
DOB _____/ ____/ ____ Age _____ Weight _____lbs. Name of School _____ Grade _____

Child's Home Address _____ City _____ State_____ Zip _____

PARENTS/GUARDIANS INFORMATION

Name _____ Relationship to Child _____SSN ___ - __ - ___ DOB ____/ ____/ ____
Check here if address is same as child's: ☐
Address _____ City _____ State_____ Zip _____

Best Phone (____) _____-_____ Alternate Phone (____) _____-_____ E-Mail _____

Occupation _____Work Phone (____) _____-_____ Marital Status: Married / Divorced / Widowed / Single

Name _____ Relationship to Child _____SSN ___ - __ - ___ DOB ____/ ____/ ____
Check here if address is same as child's: ☐
Address _____ City _____ State_____ Zip _____

Best Phone (____) _____-_____ Alternate Phone (____) _____-_____ E-Mail _____

Occupation _____Work Phone (____) _____-_____ Marital Status: Married / Divorced / Widowed / Single

MEDICAL HISTORY

Please answer the following questions as thoroughly as possible and circle the appropriate responses.

Name of child's pediatrician _____ City _____ Phone (___) _____ - _____
Describe your child's overall physical health: Excellent / Good / Fair / Poor
Is your child currently under the care of a physician? Y / N
Physician's name _____ Phone (___) _____ - _____ Specialty _____
Has your child had any serious illness or injury? Y / N
Description, including age _____
Have your child's tonsils or adenoids been removed? Y / N Is your child current on all vaccinations? Y / N

Has your child ever had any of the following?

Abnormal Blood Pressure	Y / N	Cold Sores / Fever Blisters	Y / N	Growth Problems	Y / N	Physical Disability	Y /N
AIDS/HIV	Y / N	Concussion	Y / N	Hearing Impaired	Y / N	Radiation Therapy	Y / N
Anemia	Y / N	Congenital Birth Defect	Y / N	Heart Problems / Murmur	Y / N	Rheumatic Fever	Y / N
Asthma	Y / N	Congenital Heart Defect	Y / N	Hepatitis	Y / N	Scarlet Fever	Y / N
Behavioral Disability	Y / N	Diabetes	Y / N	Kidney Problems	Y / N	Sickle Cell Anemia	Y / N
Bleeding Disorder	Y / N	Dizziness / Fainting Spells	Y / N	Liver / GI Problems	Y / N	Sinus Problems	Y / N
Blood Transfusion	Y / N	Endocrine Disorders	Y / N	Lupus	Y / N	Skin Problems	Y / N
Breathing Problem	Y / N	Epilepsy / Seizures	Y / N	Measles	Y / N	Thyroid Problems	Y / N
Bone Disorders	Y / N	Frequent Cough	Y / N	Mental / Learning Disability	Y / N	Tonsillitis	Y / N
Cancer / Leukemia	Y / N	Frequent Headaches	Y / N	Mitral Valve Prolapse	Y / N	Tuberculosis	Y / N
Chemotherapy	Y / N	Frequent Infections	Y / N	Mononucleosis	Y / N	Vision Problems	Y / N

Any disease, condition or problem not listed above? _____
Any **ALLERGIES** (including to medication)? _____
All medications currently being taken _____

DENTAL HISTORY

Please answer the following questions as thoroughly as possible and circle the appropriate responses.

1. Who may we thank for referring you? _____
2. Is this your child's first dental visit? Y / N

Previous Dentist: _____Date of Last Dental Exam / Cleaning: ____/____/____

3. What is your reason for bringing your child to the dentist today? _____
4. Has your child experienced any problems with previous dental work? Y / N

   If yes, please explain _____
5. Is your child nervous or frightened about dental visits? Yes / Somewhat / No
6. Have there been any injuries to your child's teeth, jaw, or chin? Y / N

   If so, please explain _____
7. Does your child take fluoride supplements or drink fluoridated water? Y / N
8. Has your child ever been seen by an orthodontist? Y / N

   If yes, name: _____ Date: _____ Location: _____
9. Does your child brush his/her teeth daily? Y / N Do they require parental help? Y / N
10. Does your child floss his/her teeth daily? Y / N Do they require parental help? Y / N
11. Does your child have any of the following:

Sleep Apnea	Y / N	Clenching/Grinding	Y / N	Speech Problems	Y / N
Thumb/Finger/Lip Sucking	Y / N	Chewing on Objects	Y / N	Mouth-breathing	Y / N
Nursing Bottle Habits	Y / N	Tongue Thrust	Y / N	TMJ/TMD Pain	Y / N
Pacifier Sucking Habits	Y / N	Snoring	Y / N	Nail Biting/Lip Sucking	Y / N

DENTAL PPO INSURANCE INFORMATION

Primary Insurance Company _____ Ins. Co. Phone (____) _____ -_____

Policy Holder's Employer _____ Group # _____ID #_____

Policy Holder's Name _____D.O.B. _____ / _____ / _____ SSN _____ / ____ / _____

Relationship _____ Occupation _____

Insurance Co. Address _____ City _____ State_____ Zip _____

Policy Holder's Address _____ City _____ State_____ Zip _____

Employment Address _____ City _____ State_____ Zip _____

Secondary Insurance Company _____ Ins. Co. Phone (____) _____ -_____

Policy Holder's Employer _____ Group # _____ID #_____

Policy Holder's Name _____D.O.B. _____ / _____ / _____ SSN _____ / ____ / _____

Relationship _____ Occupation _____

Insurance Co. Address _____ City _____ State_____ Zip _____

Policy Holder's Address _____ City _____ State_____ Zip _____

Employment Address _____ City _____ State_____ Zip _____

Cancellation Policy: We make every effort to accommodate the busy schedules of our patients and their families. If you are unable to attend your appointment for any reason, we require that you notify our office **AT LEAST 24 HOURS** in advance. If you do not notify us 24 hours in advance, you will be charged a $50 fee. (Initials) _____

To the best of my knowledge the information I have provided on this form is correct, and 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 authorize Michael A. Shannon, D.D.S., M.S., Inc. Pediatric Dentistry to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payers and/or other health practitioners. I have received a copy of this office's Notice of Privacy Practices (HIPAA). I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities, and healthcare operations

Responsible Party Signature:_____ Date:_____