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 _____ Zip _____

PARENTS/GUARDIANS INFORMATION

Name _____ Relationship to Child_____ SSN _____-___-_____ DOB _____/ ____/ ____
Check here if address is same as child's: ☐
Address_____ City_____ 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_____ 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.

Describe your child's overall physical health: Excellent / Good / Fair / Poor

1. Is your child currently under the care of a physician? Y / N
   If yes, please describe _____
2. Has your child had any serious illness or injury? Y / N
   If yes, please describe (include age) _____
3. Have your child's tonsils or adenoids been removed? Y / N
4. Is your child current on all vaccinations? Y / N
5. Has your child ever had any of the following:

Abnormal Bleeding	Y / N	Congenital Birth Defect	Y / N	Heart Murmur	Y / N	Rheumatic Fever	Y /N
AIDS/HIV	Y / N	Congenital Heart Defect	Y / N	Hemophilia	Y / N	Scarlet Fever	Y / N
Allergies	Y / N	Diabetes	Y / N	Hepatitis	Y / N	Seizures	Y / N
Anemia	Y / N	Endocrine Disorders	Y / N	Hives	Y / N	Sickle Cell Anemia	Y / N
Asthma	Y / N	Epilepsy	Y / N	Kidney Problems	Y / N	Sinus Problems	Y / N
Bleeding Disorders	Y / N	Frequent Infections	Y / N	Liver/GI Problems	Y / N	Shortness of Breath	Y / N
Blood Pressure	Y / N	Hearing Impaired	Y / N	Lupus	Y / N	Significant Injuries	Y / N
Blood Transfusions	Y / N	Behavioral Disabilities	Y / N	Measles	Y / N	Tonsillitis	Y / N
Breathing Problems	Y / N	Learning Disabilities	Y / N	Mitral Valve Prolapse	Y / N	Tuberculosis	Y / N
Bone Disorders	Y / N	Mental Disabilities	Y / N	Mononucleosis	Y / N	Thyroid Problems	Y / N
Cancer/Tumors	Y / N	Physical Disabilities	Y / N	Recurrent Headaches	Y / N	Vision Problems	Y / N
Chicken Pox	Y / N	Growth Problems	Y / N	Heart Problems	Y / N		

Does your child have any disease, condition or problem not listed above? _____
Name of child's pediatrician _____ City _____ Phone #(___) _____ - _____
Please list **ALL medications** your child is currently taking _____
Please list **ALL allergies** your child has, including to medication _____

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: ____/____/____ Date of Last 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

Name of Primary Insurance Company _____ Insurance Co. Phone # (____) _____ -_____

Insurance Co. Address _____ City _____ State_____ Zip_____

Policy Holder's Name _____Group # _____ID #_____

Relationship _____ D.O.B. _____ / _____ / _____ SSN _____ / ____ / _____

Policy Holder's Address _____ City _____ Zip _____

Occupation _____ Policy Holder's Employer _____

Employment Address _____ City _____ Zip _____ Phone # (____) _____-_____

Name of Secondary Insurance Company _____ Insurance Co. Phone # (____) _____ -_____

Insurance Co. Address _____ City _____ State_____ Zip_____

Policy Holder's Name _____ Group # _____ID #_____

Relationship _____ D.O.B. _____ / _____ / _____ SSN _____ / ____ / _____

Policy Holder's Address _____ City _____ Zip _____

Occupation _____ Policy Holder's Employer _____

Employment Address _____ City _____ Zip _____ Phone # (_____) _____-_____

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:_____