



**Welcome!** We at Janesville Pediatric Dental Care are pleased that your child/children will be joining our dental home as a new patient/s. Our Staff of Doctors: Dr. Gregg Dickinson, Dr. Jaclyn Martin, and Dr. Amy Kramer have dedicated their careers to providing your child with the best that dentistry has to offer.

Informing the parent is a priority at Janesville Pediatric Dental Care. A member of our staff will meet with you prior to your child/children's appointment to discuss any cares, concerns, or questions you may have. You will be asked at that time to have a seat in the reception area with the other parents as your child visits the clinical area. Our staff members will make this transition as easy as possible for both your child/children and you. Please be aware if at anytime our staff feels the necessity for parent assistance they will inform you.

During a new patient appointment your child/children will receive a professional cleaning, necessary radiographs (x-rays), fluoride treatment, and a comprehensive oral examination. Feel confident that your child/children are receiving the highest quality of dental care.

To help make your initial appointment a success we ask that you complete the attached registration and health history paperwork prior to your arrival, as well as providing a copy of your insurance card to remain on file for the submission of your dental claims. Please familiarize yourself with the details of your dental insurance plan so we may assist you in estimating your portion of any diagnosed treatment costs. If your child/children are uninsured, a staff member would be happy to give you an estimate. Payment in full will be required at the date of service. Our office does offer financing options.

If you have any questions or concerns regarding your upcoming appointment, please feel free to contact us at (608)756-3149. We look forward to meeting both you and your child/children, and welcome to our dental family!

Looking forward to meeting you,

The Janesville Pediatric Dental Care Family



Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

**RESPONSIBLE PARTY**

The parent(s) who bring the child(ren) to their initial visit is the responsible party for the account. In the case of divorce or separation the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child, irregardless of who carries the insurance, is the parent responsible for those subsequent charges, if the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other.

**Who is responsible for the account? (if married, both parents are responsible)**

Parent/Guardian #1: \_\_\_\_\_

Parent/Guardian #2: \_\_\_\_\_

Marital Status?: Married Single Divorced Separated

Marital Status?: Married Single Divorced Separated

Relation to Patient: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Street Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_

E-mail: \_\_\_\_\_

E-mail: \_\_\_\_\_

How did you hear about our office? (Circle) Internet Phonebook Friend Flyer Dentist

Please list name of referring Dentist or friend: \_\_\_\_\_

How do you prefer to be contacted: (Circle) E-mail Home Phone Cell Phone Mail

**DENTAL INSURANCE**

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

Name of Insured: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Occupation: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Group #: \_\_\_\_\_

Group #: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf of my dependants.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Payment for services and estimated insurance co-payments are due at time of service unless other arrangements have been approved in writing. It is also my understanding that 2 (two) consecutive broken appointments without explanation will lead to the dismissal of my family as patients.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Medical History Form

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_

**MEDICAL HISTORY**

Does the **Patient** have any history of the following?

- |  |     |    |     |
|--|-----|----|-----|
| Heart Problems or murmur .....                                   | YES | NO | (?) |
| Rheumatic fever .....  | YES | NO | (?) |
| Bleeding or clotting problems .....                              | YES | NO | (?) |
| Sickle cell anemia or trait .....                                | YES | NO | (?) |
|  |     |    |     |
| Cleft lip or palate .....  | YES | NO | (?) |
| Birth defects or genetic disorders .....                         | YES | NO | (?) |
| Epilepsy or seizures .....                                       | YES | NO | (?) |
| Mental retardation .....   | YES | NO | (?) |
| Autism/Developmental Delay .....                                 | YES | NO | (?) |
|  |     |    |     |
| Growth problems .....  | YES | NO | (?) |
| Cerebral palsy .....   | YES | NO | (?) |
| Ear or hearing problems .....                                    | YES | NO | (?) |
| Speech difficulties .....  | YES | NO | (?) |
|  |     |    |     |
| Vision problems .....  | YES | NO | (?) |
| Asthma or wheezing .....   | YES | NO | (?) |
| Allergies (hay fever, latex sensitivity, etc.) Please List _____ | YES | NO | (?) |
|  |     |    |     |
| Feeding or eating disorders .....                                | YES | NO | (?) |
|  |     |    |     |
| Hepatitis or liver disease .....                                 | YES | NO | (?) |
| Diabetes .....   | YES | NO | (?) |
| Tuberculosis .....   | YES | NO | (?) |
| Kidney problems .....  | YES | NO | (?) |
|  |     |    |     |
| Bone or joint problems .....                                     | YES | NO | (?) |
| Drug or alcohol use .....  | YES | NO | (?) |
| Smoking or use of snuff or smokeless tobacco .....               | YES | NO | (?) |
| Sexually transmitted or venereal disease (VD) .....              | YES | NO | (?) |
|  |     |    |     |
| AIDS or AIDS-related complex .....                               | YES | NO | (?) |
| Cancer .....   | YES | NO | (?) |
| Radiation Therapy .....  | YES | NO | (?) |
| Other medical problems (specify) _____                           | YES | NO | (?) |

Name of patient's physician \_\_\_\_\_ Date of last visit \_\_\_\_\_  
 Address \_\_\_\_\_ Phone # \_\_\_\_\_

- |  |     |    |     |
|--|-----|----|-----|
| Is the patient currently under the care of a physician? .....  | YES | NO | (?) |
| If yes, for what condition? _____  |     |    |     |
| Has your medical doctor instructed you to have your child take Penicillin before each dental visit ..... | YES | NO | (?) |
| Is the patient currently taking any medications? .....   | YES | NO | (?) |
| If yes, list _____   |     |    |     |
| for what condition? _____  |     |    |     |
| Has the patient had any allergic or unfavorable reaction any medications? .....                          | YES | NO | (?) |
| To what? _____ Reaction _____  |     |    |     |
| Have you or your child had any complications due to anesthesia? .....                                    | YES | NO | (?) |
| Has the patient ever been hospitalized? .....  | YES | NO | (?) |
| Age _____ Reason _____   |     |    |     |
| Are the patient's immunizations up-to-date? .....  | YES | NO | (?) |
| Is there any additional medical information about the patient not reported above? .....                  | YES | NO | (?) |
| If yes, describe _____   |     |    |     |

**DENTAL HISTORY**

Why is the patient seeking dental care? \_\_\_\_\_

Is this the patient's first visit to a dentist? ..... YES NO (?)  
 If no, please provide name of dentist and date of last visit \_\_\_\_\_

Has the patient had any of the following dental problems?  
 Injuries to mouth or teeth ..... YES NO (?)  
 Toothaches/pain ..... YES NO (?)  
 Abscesses (gum boils) ..... YES NO (?)  
 Other (specify) \_\_\_\_\_

Does the patient have any of the following habits?  
 Finger/thumb/pacifier sucking ..... YES NO (?)  
 Tooth grinding or clenching ..... YES NO (?)  
 Other (specify) \_\_\_\_\_

At what age was bottle or breast feeding stopped? \_\_\_\_\_

What is the source of the patient's current drinking water supply?  
 \_\_\_\_\_ City \_\_\_\_\_ Home well \_\_\_\_\_ Bottled \_\_\_\_\_ Don't know

Is this water fluoridated? ..... YES NO (?)  
 Does patient receive fluoride tablets, drops or vitamins with fluoride? ..... YES NO (?)  
 Who is responsible for brushing the patient's teeth? \_\_\_\_\_  
 Is there any additional dental information we should know? ..... YES NO (?)  
 If yes, describe \_\_\_\_\_

**SOCIAL & BEHAVIORAL HISTORY**

Do you think the patient will cooperate for dental treatment? ..... YES NO (?)  
 Has the patient had a bad or fearful dental or medical experience? ..... YES NO (?)  
 Which of the following best describes the patient?  
 \_\_\_\_\_ Advanced in the learning process \_\_\_\_\_ Progressing normally \_\_\_\_\_ Slow learner

Does the patient have any history of emotional or behavioral problems? ..... YES NO (?)  
 If yes, describe \_\_\_\_\_

Are there any cultural, religious or ethnic concerns that could affect the care of your child? ..... YES NO (?)  
 If yes, describe \_\_\_\_\_

Names and ages of other children in the family \_\_\_\_\_

Is there any additional information we should know? ..... YES NO (?)  
 If yes, comment \_\_\_\_\_

In case of hospitalization, trauma or emergency, please provide the name of your medical Insurance provider/company \_\_\_\_\_

To the best of my knowledge the above information is correct.

Signature of person completing form	Date	Relationship to patient