Welcome to A+ Pediatric Dentistry of Atlanta

We are complimented that you have selected us to provide dental care for you and your family.
Please review this print-out, and sign the Consent For Treatment on Page 2.

CHILD INFORMATION

Child's Full Name: Date Submitted:

Nickname: Gender: ☐ **Male** ☐ **Female**

Child's Social Security No.: Child's Birthdate: Age:

List of anyone who may accompany the patient and their relationship to the patient:

How did you hear about us?

PARENT OR GUARDIAN INFORMATION

Parent or Guardian's Name: Social Security No.:

Email: Birthdate:

Address:

City: State: Zip:

Home Phone: Mobile Phone:

Employer: Occupation:

Duration of Employment

Marital Status:

Spouse's Name: Spouse Social Security No.:

Spouse Email: Spouse's Birthdate:

Spouse's Home Phone: Spouse's Mobile Phone:

Spouse Employer: Spouse Occupation:

Duration of Employment:

BILLING INFORMATION (IF DIFFERENT THAN PARENT INFORMATION)

Billing Name: Social Security No.:

Billing Address:

Billing City: State: Zip:

Phone: Work Phone:

Employer: Occupation:

Duration of Employment:

Patient Name: Date Submitted:

INSURANCE INFORMATION

Policy Owner's Name: Birthdate: SS No.:

Insured's Employer:

Dental Insurance Company: Insurance Compay Phone #

Group Number: Policy #:

Address:

City: State: Zip:

MEDICAL HISTORY

Patient's primary care physician: Physician's Phone:

How would you describe your child's overall health?

When was the child's last physical?

Has your child been hospitalized for a surgical procedure? ☐ **Yes** ☐ **No**

If so, why?

Has your child been hospitalized for a non-surgical procedure? ☐ **Yes** ☐ **No**

If so, why?

Is your child currently taking any medications? ☐ **Yes** ☐ **No**

If so, please list each medication and the reason it is being taken:

Has your child ever had an adverse reaction or allergies to any medication or substance? (Please check if allergic. If none apply please check the "none" option) *

☐ **None**
☐ **Aspirin**
☐ **Codeine**
☐ **Erythromycin**
☐ **Iodine**
☐ **Latex**
☐ **Novocaine**
☐ **Nitrous Oxide**
☐ **Penicillin**
☐ **Sulfa Drugs**
☐ **Tetracycline**
☐ **Valium**
☐ **Xylocaine**
☐ **Other**

Others:

Has the patient ever had any of the following? (Please check all that apply If none apply please check the "none" option) *

☐ **None**
☐ **Heart problems (Murmur etc.)**
☐ **Blood or bleeding disorder**
☐ **Breathing problems (Asthma etc.)**
☐ **Muscular problems**
☐ **Bone or joint problems**
☐ **Nervous disorder (Seizures, epilepsy)**
☐ **Behavior issues (ADHD etc.)**
☐ **Mental disorder (Autism etc.)**
☐ **Hormone, kidney or liver problem (Diabetes)**
☐ **Digestion problems**
☐ **Cancer**
☐ **Pregnancy**
☐ **Vision, hearing or speaking problems**
☐ **Surgeries**
☐ **Other**

Does your child have any condition or problem not listed which we should know about? Please explain:

Patient Name: Date Submitted:

DENTAL HISTORY

Reason for this visit?

Is this your child's first dental visit? ☐ **Yes** ☐ **No**

If no, date of last visit: Date of last x-ray:

Treatment performed:

Name of former dentist:

Phone: Type of dentist:

Was your child breast fed? ☐ **Yes** ☐ **No** ☐ **Currently** If yes, until what age?

Was your child bottle fed? ☐ **Yes** ☐ **No** ☐ **Currently** If yes, until what age?

Has your child ever had any injuries to his or her teeth, mouth, head or jaws? ☐ **Yes** ☐ **No**

If yes, please describe:

Your child drink juice or soda most days? ☐ **Yes** ☐ **No**

Your child eat sweets, chips or gummies most days? ☐ **Yes** ☐ **No**

Does your child brush daily? ☐ **Yes** ☐ **No**

Does an adult assist with brushing ☐ **Yes** ☐ **No**

Does your child floss? ☐ **Yes** ☐ **No**

Does an adult assist with flossing? ☐ **Yes** ☐ **No**

Does your child have any of the following mouth habits:

☐ **None** ☐ **Mouth Breathing** ☐ **Lip Sucking** ☐ **Pacifier**
☐ **Finger Sucking** ☐ **Teeth Grinding** ☐ **Nail Biting** ☐ **Tongue Thrusting**

Other:

Does your child receive fluoride in any of the following forms:

☐ **Vitamins** ☐ **Tooth Paste** ☐ **Rinse/Gel**
☐ **Water Supply** ☐ **Tablets/Drops**

Other:

Has your child had any bad dental or medical experiences in the past? ☐ **Yes** ☐ **No**

If yes, please explain:

Please check any of the following that may describe your child:

☐ **Anxious** ☐ **Defiant** ☐ **Mellow** ☐ **Shy** ☐ **Suspicious**
☐ **Cooperative** ☐ **Friendly** ☐ **Moody** ☐ **Stubborn** ☐ **Trusting**
☐ **Curious** ☐ **Hyper** ☐ **Outgoing**

Child's interests:

Favorite sport: Favorite movie:

How can we make this a more positive experience for your child?

NEAREST RELATIVE

Name of nearest relative not living with you?

Phone:

Relationship to the patient?

CONSENT FOR TREATMENT

I hereby authorize Dr. Howard, Jaha to administer any treatment and to perform such x-rays, anesthetics, and dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.

I authorize release of any information relating to this claim. I realize that I am ultimately responsible for all costs of dental treatment.

I hereby authorize my insurance benefits to be paid directly to Pediatric Dentistry of Atlanta.

Date:_____ Signature (patient or parent for minor)_____

After initial x-rays and examination, we will give you an estimate of fees to cover your treatment. At that time financial arrangements will be made before treatment is rendered.

Preferred method of payment: _____Cash _____Check _____Bankcard