Ronald L. Poulos, DDS
Dentistry for Children

Welcome To Our Office!

Today's Date _____

Child's Name _____ Sex: M F Nickname _____

Birthdate _____ Age _____ Home Phone _____

Address _____

Email Address _____

Siblings Names & Ages _____

Responsible Party

Mother Birthdate ____/____/____ Social Security No. _____ - ____ - _____

Last Name _____ First Name _____ M.I. _____

Address _____ Home Phone _____ Cell _____

City _____ State _____ Zip Code _____

Employed By _____ Work Phone _____

Employer Address _____

Father Birthdate ____/____/____ Social Security No. _____ - ____ - _____

Last Name _____ First Name _____ M.I. _____

Address _____ Home Phone _____ Cell _____

City _____ State _____ Zip Code _____

Employed By _____ Work Phone _____

Employer Address _____

Parent's Marital Status: (Circle one) Married Divorced Separated Single

Legal Guardian: (Circle one) Mom Dad Other (Please Name) _____

Person Financially Responsible For Child _____ Phone _____

Address _____

Emergency Contact: Name _____ Phone _____

Dental Insurance

Primary Insurance Co. _____ Group No. _____

Address _____

Policy Holder _____ Relation To Patient _____

Secondary Insurance Co. _____ Group No. _____

Address _____

Policy Holder _____ Relation To Patient _____

Whom May We Thank For Your Referral _____

I Accept Responsibility For This Account _____
Signature of Parent or Guardian

Ronald L. Poulos, DDS
Dentistry for Children

Health History

Patient's Physician _____ Phone # _____

Physician's Address _____

1. Is your child under the care of a physician for any illness or health problem? ..... ❑ Yes ❑ No
2. Does your child have or ever had any of the following health conditions?

Abnormal Bleeding Problems	❑ Yes	❑ No	Fainting	❑ Yes	❑ No
Aids or Aids Related Complex	❑ Yes	❑ No	Hearing Problems	❑ Yes	❑ No
Allergies	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Heart Problems	❑ Yes	❑ No
Asthma or Other Respiratory Problems	❑ Yes	❑ No	Hepatitis, Jaundice or Liver Problems	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No
Artificial Limb or Implant	❑ Yes	❑ No	Hyperactivity	❑ Yes	❑ No
Bladder Disorder	❑ Yes	❑ No	Kidney Disorders	❑ Yes	❑ No
Blood Disorder	❑ Yes	❑ No	Learning Disability	❑ Yes	❑ No
Blood Transfusion	❑ Yes	❑ No	Developmental Disability	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Premature Delivery	❑ Yes	❑ No
Cerebral Palsy	❑ Yes	❑ No	Pregnancy	❑ Yes	❑ No
Convulsions or Seizures	❑ Yes	❑ No	Radiation Therapy	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Rheumatic Fever or Heart Disease	❑ Yes	❑ No
Ear, Nose or Throat Problems	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Emotional Problems	❑ Yes	❑ No	Hyper or Hypo Thyroidism	❑ Yes	❑ No

Please explain "yes" answers _____

_____

_____

3. Does your child have any disease, syndrome or handicap not listed above? ..... ❑ Yes ❑ No

   If yes, describe _____
4. Is your child taking any over the counter drugs or prescription medications? ..... ❑ Yes ❑ No

   If yes, name of medication(s) _____
5. Has your child had any allergies or any adverse side affects to any drugs or medications, including local anesthetic, penicillin, codeine, fluoride, etc.? ..... ❑ Yes ❑ No

   If yes, name of medication(s) _____
6. Has your child ever been hospitalized? ..... ❑ Yes ❑ No
7. Has your child ever had any surgeries? ..... ❑ Yes ❑ No
8. Has your child or any relative had a problem with general anesthesia? ..... ❑ Yes ❑ No

Doctor Notes _____

_____

_____

_____

_____

_____

_____

Ronald L. Poulos, DDS
Dentistry for Children

Dental Information

1. Is this your child's first visit to the dentist? ..... ❑ Yes ❑ No
2. Has your child complained about dental problems? ..... ❑ Yes ❑ No
3. When was your child's last trip to the dentist? ..... ❑ Yes ❑ No

   Name of previous dentist _____
4. Has your child had an unhappy dental experience? ..... ❑ Yes ❑ No
5. Who brushes your child's teeth? _____ How Often? _____
6. Do you drink well water, city water or bottled water? _____
7. Is your child going to sleep with a bottle? ..... ❑ Yes ❑ No
8. What does the bottle contain: ❑ Water ❑ Milk ❑ Formula ❑ Juice ❑ Other
9. Is your child presently breast feeding? ..... ❑ Yes ❑ No
10. Any oral habits (thumb sucking, pacifiers, nail biting, etc.)? ..... ❑ Yes ❑ No
11. Any history of injuries to mouth, teeth, or head? ..... ❑ Yes ❑ No

    If yes, describe injury _____

The statements on both sides of this form are, to the best of my knowledge true and correct. I agree to report any health changes to the Doctor prior to any treatment. I hereby authorize the Doctor and staff to provide examinations, x-rays and procedures to diagnose oral and dental disease and to provide necessary dental services.

_____ _____ _____

Patients Name *Signature of Parent or Legal Guardian* *Date*

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, acknowledge that I have been given the opportunity to read a copy of this office's Notice of Privacy Practices, and I am aware that a copy will be made available at my request.

_____ _____
(Please Print Name) (Date)

_____
(Signature)

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment count not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please Specify)