

PEDIATRIC DENTISTRY, P.A.

L. Lee Cope, D.D.S.



Thank you for giving us the privilege of seeing your child. We are anxious to provide the best possible care. Answers to these questions will help make this possible.

Child's Name _____ Nickname, if any _____

Birthdate _____ Age _____ Hobbies _____

Attending what school _____ Grade _____

Home Address _____ City, State, Zip _____

Home Phone Number _____ Physician or Pediatrician _____

Family Dentist _____ Purpose of this visit? _____

Whom may we thank for referring you to our office? _____

Names and ages of brothers _____

Names and ages of sisters _____

Father's full name _____ Employed by _____ Phone _____

Father's S.S.# _____ Father's D.L.# _____ Mother's S.S.# _____ Mother's D.L.# _____

Mother's full name _____ Employed by _____ Phone _____

Type of Insurance: Medical _____ Dental _____ Company Name _____ Phone _____

Do you have a checking account? _____ Name of bank? _____ Do you have a credit card? _____ Type? _____

Person responsible for account if other than above _____

Address _____ City, State, Zip _____ Phone _____

Do mother, father and child all live together? _____ If no, please explain _____

Have you ever been in our office before? _____ For what reason? _____

MEDICAL INFORMATION: PLEASE RESPOND TO EVERY QUESTION (Check one)

- A. Has your child ever been hospitalized or been in a hospital? Yes No Emergency Room? Yes No
If yes, why? _____
- B. Is your child now under the care of a physician, other than regular check ups? Yes No If yes, why? _____
- C. Is your child pregnant? Yes No
- D. Does your child take any type of fluoride? Yes No
- E. Is your child taking any other medications? Yes No If so, what? _____
- F. Is your child allergic to anything? Yes No If so, what? _____
- G. Has your child ever had a reaction to penicillin or any other drugs? Yes No If so, what? _____
- H. Have there ever been any injuries to the teeth, chin, or other parts of the face? Yes No When? _____
- I. Does your child have frequent headaches or frequently grind his/her teeth? Yes No When? _____
- J. Does your child have tenderness in the muscles of the mouth? Yes No When? _____
- K. Does your child's jaw joint make a noise when he/she opens or closes his/her mouth? Yes No How often? _____
- L. Is there any other information that might be valuable to us in treating your child? Yes No If so, what? _____
- M. Does your child now have or has he or she ever had the following:

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Disease (digestive)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (seizures)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease or Trait	<input type="checkbox"/>	<input type="checkbox"/>	Glandular or Hormonal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Speech, Learning, or Hearing Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	Brain Damage	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Hypothermia	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	AIDS (HIV infection)	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>			

- 1. Does your child have any history of thumb-sucking, finger-sucking, lip biting, nail biting, or taking a bottle or pacifier after one year old? **(If yes, please circle)** _____
- 2. How do you expect your child to behave at this visit? _____
- 3. How has he reacted to past medical experiences? _____
- 4. Does your child brush his teeth/how often? _____ Floss, how often? _____
- 5. Does your child eat frequent between meal snacks? Yes No / or a well balanced diet? Yes No (Please check)
- 6. Has your child had a toothache recently? Yes No Any other dental problem? Yes No
- 7. Give date of last dental care _____ Where? (city) _____ Dr. _____ For what reason? _____

Thank you for assistance in completing this questionnaire.

CONSENT FORM

1. I, _____, being the parent or guardian of the minor patient, _____ do certify that the information supplied on page 1 of this form is correct to the best of my knowledge.
2. I hereby do authorize and request the performance of dental services for this patient and the use of whatever procedures Dr. L. Lee Cope may deem necessary during treatment.
3. I understand that Dr. Cope and such assistants as he may designate to treat the above mentioned patient will use restorative, oral surgical and patient management techniques that are reasonable, necessary and advisable. Management techniques might include restraint, mouth-prop, firm voice control or tell-show-do or any combination of the above. For the benefit of the child, the parent will be asked to remain in the reception area during treatment. However, communication is often necessary and desirable between the dental staff and the parent; at that time the parent will be asked to be present in the examination, treatment, or consultation area. No guarantee or assurance has been given by anyone as to the results that may be obtained.
4. I also authorize the administration of anesthetics or analgesics which may be deemed advisable by Dr. Cope.
5. I understand the treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology or unforeseen conditions that may necessitate additional or different procedures than those set forth in the treatment plan. I understand that I will be informed, if possible, if significant changes occur. In any event, I authorize Dr. Cope and such assistants as he may designate to perform such procedures as are in his professional judgment, necessary, and desirable, including, but not limited to, procedures involving pathology and radiology.
6. Furthermore, by signing this, I agree to be responsible for full payment of all charges for dental services performed on the above-named patient.
7. I understand that full payment for services rendered is routinely expected at the time of the visit. If under special circumstances, an account balance becomes over 30 days old, I agree to pay a \$5.00 late fee and be assessed a service charge of 15% annual percentage rate (14% per month). No account will be allowed to remain unpaid after 120 days. At that time balance, finance charges, and late fees will be due in full.

I AGREE TO PAY PEDIATRIC DENTISTRY, P.A. IN ACCORDANCE WITH THE CREDIT TERMS DISCLOSED TO ME AND TO COMPLY WITH ALL TERMS OF THE PEDIATRIC DENTISTRY, P. A., CHARGE AGREEMENT. PEDIATRIC DENTISTRY, P.A. IS AUTHORIZED TO INVESTIGATE MY CREDIT, EMPLOYMENT, AND INCOME REFERENCES AND TO REPORT MY PERFORMANCE TO PROPER PERSONS AND CREDIT BUREAUS.

Date: _____

Signed: _____

Relationship: _____

Witness: _____