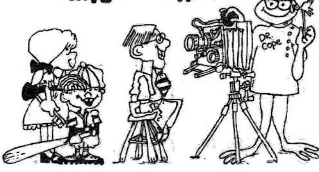

PEDIATRIC DENTISTRY, P.A.

L. Lee Cope, D.D.S.
Susan C. Fortenberry, D.M.D.

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 ________ Email ______________
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 siblings ______________________
Father's full name ______________ Employed by ______________ Phone ________
Father's S.S.# ______________ Father's D.O.B. ________ Mother's S.S.# ______________ Mother's D.O.B. ________
Mother's full name ______________ Employed by ______________ Phone ________
Type of Insurance: Medical ______ Dental ______ Company Name ______________ Medicaid # ______________ Med/Chip # ______________
Do you have a checking account? ________ Name of bank? ______________ Do you have a credit card? ________ Type? ______________
Person responsible of 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/Did 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/she ever had any of the following:

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	☐	☐	Thyroid disease	☐	☐	Hepatitis	☐	☐
Heart Disease	☐	☐	Gastrointestinal disease (digestive)	☐	☐	Diabetes	☐	☐
Heart murmur	☐	☐	Musculoskeletal disease	☐	☐	Epilepsy (seizures)	☐	☐
Liver disease	☐	☐	Sickle Cell disease or trait	☐	☐	Birth defects	☐	☐
Kidney disease	☐	☐	Blood disorders	☐	☐	Glandular or hormonal problems	☐	☐
Bladder disease	☐	☐	Brain damage	☐	☐	Speech, learning, or hearing disorders	☐	☐
Respiratory disease	☐	☐	Neurological disorders	☐	☐	Abnormal blood pressure	☐	☐
Asthma	☐	☐	Mental retardation	☐	☐	Cancer	☐	☐
Tuberculosis	☐	☐	Autism	☐	☐	Malignant hypothermia	☐	☐
Anemia	☐	☐	Cerebral palsy	☐	☐	Aids (HIV infection)	☐	☐

1. Has your child any history of thumbsucking, fingersucking, 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/she reacted to past medical experiences? ______________________
4. Does your child brush his/her 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.

PLEASE COMPLETE THE CONSENT FORM ON THE REVERSE SIDE OF THIS PAGE. ☐

CONSENT FORM

1. I, ______________________________, being the parent or guardian of the minor patient, ____________________ do certify that the information supplied on the reverse side of this page 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 and/or Dr. Susan Fortenberry may deem necessary during treatment.
3. I understand that Dr. Cope and/or Dr. Fortenberry and such assistants as he/she 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 and/or Dr. Fortenberry.
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 do occur. In any event, I authorize Dr. Cope and/or Dr. Fortenberry and such assistants as he/she may designate to perform such procedures as are in his/her professional judgement, 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, and 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 (1 1/4% per month). No account will be allowed to remain unpaid after 120 days. At that time balance, finance charge, and late fee 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 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:____

PEDIATRIC DENTISTRY, P.A.

I,____ have received a copy of this office's
(Please Print)
Notice of Privacy Practices.

Signed: ____

Date:____