CCDC New Patient Form

Child's Name_____ Nickname_____ Sex: M F

Reason For Visit:_____ DOB:_____

Child's Interests:_____ Any Pets?_____

Name of School:_____ SSN:_____

Names and Ages of Brothers and Sisters:_____

How do you think your child will act towards Dr. Paulson?_____ Explain:_____

How did you hear about us?_____

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

Dental History

Is this your child's first dental visit? Y N Previous dentist:_____
City

Is your child doing any of the following? (Please circle) Thumb/finger sucking Pacifier

Grinding Nursing Bottle-feeding Mouthbreathing Nail-biting Lip-sucking

Any history of injuries to your child's teeth or mouth? Y N Describe:_____

Health History

Child's Physician:_____ Phone:_____

Is your child currently under the care of a physician: Y N If yes, for what?_____

Is your child taking any medications? Y N If yes, please list:_____

Is your child allergic to anything? Y N If yes, please list:_____

History of surgery or hospitalization? Y N If yes, please list w/ dates:_____

Pharmacy you like to use?_____

History of nighttime snoring? Y N Ear infections? Y N Any speech delays? Y N

Has your child had a history or difficulty with any of the following (check any that apply):

- [] ADHD/ADD
- [] Allergies (seasonal)
- [] Asthma
- [] Autism
- [] Bleeding disorder
- [] Bone Disorder
- [] Cancer
- [] Cardiac Disease
- [] Cerebral Palsy
- [] Chemo/Radiation Therapy
- [] Developmental Delay
- [] Diabetes
- [] Down Syndrome
- [] Epilepsy/Seizure
- [] Hearing Impaired
- [] Heart Murmer
- [] HIV
- [] Hepatitis
- [] Immune Disorder
- [] Kidney/Liver Dysfunction
- [] Premature Birth
- [] Rheumatic fever/Heart
- [] Tuberculosis
- [] Vision Impaired

Other:_____

Preventive Dental History

How often does your child brush?_____ Is toothbrushing supervised? Y N

What brand of toothpaste?_____ Is dental floss used? Y N How often? _____

Breast fed? Y N To what age? _____ Bottle fed? Y N To what age?_____

Family Information

Mailing Address:_____

Mother's Full Name:_____ SSN:_____ DOB:_____

Address (if different):_____ Phone number:_____

Place of Employment:_____

Father's Full Name:_____ SSN:_____ DOB:_____

Address (if different):_____ Phone number:_____

Place of employment:_____

Has any member of your family been a patient here before? Y N Please list:

Emergency Contact

Name:_____ Address:_____ Phone:_____

Authorization and Financial Responsibility

Is your child covered by a dental insurance plan? Y N

Name of Parent insured:_____ Group/Policy #:_____

Insurance company:_____ Address:_____

Is your child eligible for state aid? Y N Medicaid #_____

-I have received the treatment plan, I authorize the release of any information relating to insurance claims, and I understand that I am responsible for all costs of dental treatment.

Signature of parent/guardian:_____ Date:_____

-I hereby authorize payment directly to Casper Children's Dental Clinic of the group insurance benefits otherwise payable to me.

Signature of parent/guardian:_____ Date:_____

I hereby authorize Dr. Roy E. Paulson and/or his associates to perform any and all treatment for the above named child and consent to such methods, medications, and agents as may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled by either party. I will be responsible for the cost of this dental care. In the event that the amounts due are not paid, a monthly finance charge of 1.75% will be assessed on all unpaid accounts 60 days past service date. If this matter is turned over to collections, I will be responsible for all costs and attorney fees.

Signature of parent/guardian:_____ Date:_____