building blocks PEDIATRIC DENTISTRY

Your Child

Child's Name _____ Sex_____ Age_____

Nickname _____ SS# _____ Birthdate _____

School _____ Grade _____

Child's Home Address _____

City _____ State_____ Zip_____ Phone _____

Responsible Party

☐ mother ☐ stepmother ☐ father ☐ stepfather ☐ guardian

Name _____

Address _____ Email _____

City _____ State _____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone _____

Employer _____ Occupation_____ SS# _____

Marital Status ☐ single ☐married ☐ separated ☐ divorced ☐ widowed

Additional Parent or Guardian

☐ mother ☐ stepmother ☐ father ☐ stepfather ☐ guardian

Name _____

Address _____ Email _____

City _____ State _____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone _____

Employer _____ Occupation_____ SS# _____

Marital Status ☐ single ☐married ☐ separated ☐ divorced ☐ widowed

Additional Parent or Guardian

☐ mother ☐ stepmother ☐ father ☐ stepfather ☐ guardian

Name _____

Address _____ Email _____

City _____ State _____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone _____

Employer _____ Occupation_____ SS# _____

Marital Status ☐ single ☐married ☐ separated ☐ divorced ☐ widowed

Primary Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS# _____ Employer _____

Insurance Co. Name _____

Additional Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS# _____ Employer _____

Insurance Co. Name _____

Dental/Medical History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely

How often does your child brush? _____
How often does your child floss? _____
Is your child's water fluoridated? _____
Does your child take fluoride supplements?_____

Does your child:

Suck Thumb/Finger	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew Hard Objects (pencils,etc.)	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No

Date of Last Dental Visit _____

What Was Done at That Visit? _____

Previous Dentist

_____

Address

_____

Has your child had difficulty with previous dental visits?
☐ yes ☐ no
If yes, please explain

_____

Whom may we thank for referring you?

_____

Names of other family members seen by us?

_____

Child's Physician _____
Address _____
Phone # _____

Has your child ever had any of the following:

Autism:	☐ Yes	☐ No
Asthma:	☐ Yes	☐ No
ADHD	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Stomach, Liver or Kidney Problems	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No

Previous Hospitalizations/Surgeries/Serious illnesses? When?

_____ _____

_____ _____

Is your child currently taking any medications? ☐ Yes ☐ No If yes please list _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocaine,etc)?☐ Yes☐ No

If yes, please describe _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Please explain any medical problems that your child has: _____

_____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Any additional charges or fees left unpaid can be subject to collection or legal fees up to 40%.

Financial Arrangements

For your convenience, we offer the following methods of payment. Payment, including any deductibles or co-pays, is due in full at each appointment.
☐ Cash ☐ Personal Check ☐ Visa ☐ MasterCard ☐ I wish to discuss the office's payment policy

_____ _____
Signature of Parent/Guardian Date

Judith Samselski DMD
2100 Quaker Pointe Drive Quakertown PA 18951
(267) 373-9402 FAX (215) 546-6010
www.buildingblocksdental.com

Dear Doctor _____:

_____ is a mutual patient of ours. On obtaining a routine health history, it was noted that _____ has the following condition:

_____

Would you kindly take a few moments to check the appropriate response and add any comments that you feel are relevant to this patient's care.

1. Need for prophylactic antibiotic coverage: _____Yes _____ No
   Oral regimen you recommend:
   Rx:
   Disp:
   Sig:
2. Contraindications to local anesthetic: _____Yes _____ No
   _____ with vasoconstrictor (normally used)
   _____ without vasoconstrictor

3. Contraindication to nitrous oxide/oxygen relative analgesia. Oxygen level not to be below 50%. Uptake by demand only. No forced intake apparatus used. For relief of patient apprehension only.
   Nitrous oxide/oxygen contraindication _____Yes _____ No

4. Please provide a brief description of this patient's condition and any additional precautions that you feel are necessary or beneficial.

Physicians Signature _____Date_____

Thank you again for your time and concern.
Regards,
Dr. Judith Samselski

PLEASE RETURN TO:
Building Blocks Pediatric Dentistry
Dr. Judith Samselski
2100 Quaker Pointe Drive
Quakertown, PA 18951
FAX (215) 546-6010