LIANN W. DRECHSEL, DMD, PC

PEDIATRIC DENTISTRY

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ MI: ____

PREFERRED NAME: _____ SEX: ____ DOB: _____

PLEASE LIST BROTHERS AND SISTERS _____

RESPONSIBLE PARTY INFORMATION (PERSON PATIENT LIVES WITH) RELATIONSHIP TO PATIENT: _____

FIRST NAME: _____ LAST NAME: _____MI: ____

DOB: _____ PHONE: _____ ALT. PHONE: _____

MAILING ADDRESS: _____CITY: _____STATE: ____ZIP: _____

EMPLOYER: _____ WORK PHONE: _____

MOTHER/FATHER (CIRCLE ONE) FIRST NAME: _____ LAST NAME: _____ MI: ____

DOB: _____ PHONE: _____ ALT. PHONE: _____

MAILING ADDRESS: _____CITY: _____STATE: ____ZIP: _____

EMPLOYER: _____ WORK PHONE: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

PRIMARY INSURANCE INFO

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

DOB:_____ Soc. Sec # _____ EMPLOYER: _____

INSURANCE COMPANY: _____ GROUP# _____ ID# _____

SECONDARY INSURANCE INFO

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

DOB:_____ Soc. Sec # _____ EMPLOYER: _____

INSURANCE COMPANY: _____ GROUP# _____ ID# _____

Notice

As a courtesy to all insured patients we will bill your insurance plan directly. Correct insurance Information along with ID numbers will be required at the time of service. Please note we are not contracted with most insurance companies. Also please understand that it is your responsibility to know and understand your dental benefits before service is rendered. Should your insurance plan deny your claim you will need to call them directly for their explanation. If you are uninsured payment for services are due at the time of service.

Payment Methods

Payment is expected at the time services are rendered. We accept a variety of payment methods, including cash, check, money order, or credit card Visa, MasterCard, and Care Credit. Credit card payments are also accepted via telephone. Payment plans with automatic deductions from an established checking account or credit card may be available.

I understand and agree to the terms in this notice

Printed Name: _____ Signature:_____ Date _____

2270 NW Troost Street Roseburg, OR 97471 **P: (541) 672-5535** F: (541) 672-7651

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PEDIATRIC DENTISTRY

HEALTH HISTORY

A-DENTAL HISTORY **Patient Name: _____**

Date of last visit to a dentist_____ Has your child complained about any dental problems? Yes/No Have there been any unhappy dental experiences for your child? Yes/No For you? Yes/No Does your child dislike going to the dentist? Yes/No Do you? Yes/No
Has your child had any injuries to the mouth, teeth or head? Yes/No Type of injury _____
Summary (DOCTOR USE) _____

Does your child brush regularly? Yes/No Do you Assist? Yes/No How often? _____ Is dental floss used in your family? Yes/No
If yes, who?_____ Are disclosing tabs used? Yes/No If yes,who?_____
Is fluoride taken? Yes/No If yes, how? Perscription/Toothpaste/Mouthwash Is xylitol used? Yes/No If yes, who? _____
What is your childs attitude toward dentistry? _____

Do you desire complete dental service for your child? Yes/No If No, please explain _____

B- MEDICAL HISTORY

Is your child in good health? Yes/No If No, please explain_____

Have you ever been told your child has a heart murmur? Yes/No Does your child have regular medical exams? Yes/No Date of last exam _____

Reason for exam_____ Has your child ever been hospitalized? Yes/No

Reason for Hospitalization _____

Has your child ever experienced an unfavorable reaction to drugs, including antibiotics or local anesthesia? Yes/No If yes, please explain____
_____

Does your child have car/motion sickness? Yes/No Do you consider your child to be: (Please choose one of the following)

Advanced in the learning process Progressing normally A slow learner

Were there any problems in the birth of this child? Y/N If yes, please explain _____

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

Has your child had any history of difficulty with any of the following? **Please circle all that apply/If none apply mark here: _____**

ADD/ADHD	BLEEDING DISORDER	DEVELOPMENTAL DELAY	HEART	MEASLES/MUMPS	
AIDS/ARC	CANCER/TURMOR	DIABETES	HEPATITIS	MENTALLY HANDICAPPED	
ANEMIA	CEREBRAL PALSY	DOWN SYNDROME	KIDNEY	MRSA	
ASTHMA	CHICKEN POX	EPILEPSY	LIVER	OSTIOPOROSIS	
AUTISM	CHRIONIC SINUS	FAINTING	LUNGS	SEIZURES	THYROID
BLADDER	CONVULSIONS	HEARING	MALIGNANCIES	SLEEP APNEA	TUBERCULOSIS

Other: _____ Are your/your child's immunizations current? Y/N _____

PRIMARY CARE PHYSICIAN /PEDIATRICIAN _____ PHONE#_____

C-Update

Legal guardian name _____ **Relationship to patient** _____

Signature _____ **Date**_____

Address:_____ **Contact #:** _____

Primary Insurance:_____ **Secondary Insurance:** _____