Huel Harris Pediatric Dentistry

1014 South 28th Avenue
Hattiesburg, MS 39402
601-268-2975
www.huelharrispediatricdentistry.com

Pediatric Demographic Information

Date _____

Patient _____
Nickname _____
Date of Birth _____ Age _____ Sex: M _____ F _____
Child's SSC# _____
Home Address _____
street city state zip
Home Phone _____
Cell Phone _____ Email _____

Names and ages of other children in family _____

Child's Physician _____
Physician Address _____
street city state zip
Physician Phone _____

Child's School Name _____
Grade _____ Teacher _____
Parent/Guardian _____ Relationship to Patient _____
Mother _____ SS# _____
Mother's Employer _____ Phone _____
Father _____ SS# _____
Father's Employer _____ Phone _____

Who has legal custody of patient? _____
Dental Insurance Provider: _____
Person responsible for payment of account _____ SS# _____
Email _____

Whom may we thank for referring you? _____
Is this your child's first dental visit? _____

What is the reason for your child's dental visit? _____

Pediatric Health History

Is your child in good health? **Yes** _____ **No** _____
Name of child's physician _____ Date of last physical exam _____

Has your child ever had a health problem? Yes _____ No _____
If yes, please explain.

_____

Has your child ever been hospitalized? Yes _____ No _____
Please give reason and dates.

_____

Is your child allergic to any medications? **Yes** _____ **No** _____

Is your child currently taking any medications? **Yes** _____ **No** _____
Please give medication, dose, and reason for taking medication.

_____

Were there any problems at birth? Yes _____ No _____

Please check if your child has been treated for any of the following:

Heart Disease	Heart Murmur	Tuberculosis	Problems at Birth
Liver/GI Disease	Kidney Disease	Speech/Hearing	Cerebral Palsy
Tonsils/Adenoids	Skin/Eczema	Cancer/Tumors	Sickle Cell Anemia
Bleeding/Transfusions	Anemia	Seizures	Rheumatic Fever
Headaches	Injuries	Sleep	Congenital Birth Defects
Asthma/Breathing	Diabetes	Hepatitis	Cleft Lip/Palate
Endocrine/Growth	Autism	ADHD	Adverse Drug Reaction
AIDS/HIV	Mental Delays	Physical Delays	Other Problems

Please explain all items checked:

_____

_____

Pediatric Dental History

Has your child been to the dentist before? Yes _____ No _____
If yes, what is the name of the dentist? _____
When was the last dental visit? _____

Has your child experienced any unfavorable reaction from previous dental care? Please explain

_____

Does your child suck a finger? _____ Thumb? _____ Pacifier? _____

Does your child have tooth pain? Yes _____ No _____

If yes, where is the pain? _____

Was your child breast fed? _____ Bottle fed? _____ Date stopped _____

Does your child sleep with a sippy cup and/or bottle? Yes _____ No _____

If yes, what beverage is normally in the sippy cup and/or bottle? _____

Who helps your child brush his/her teeth? _____

How often are your child's teeth brushed? _____

Who helps your child floss his/her teeth? _____

How often are your child's teeth flossed? _____

Please check if your child currently has or has had problems with the following:

❑ Cavities ❑ Toothache ❑ Gum Infections ❑ Jaw Sounds

❑ Teeth Sensitivity ❑ Color of Teeth ❑ Tooth/Face Injury

❑ Grinds Teeth ❑ Bad Odor ❑ Orthodontics ❑ Other

Comments:

_____

_____

Fluoride History	**Yes**	**No**
Is your home water supply fluoridated?	_____	_____
Does your child use a fluoride toothpaste?	_____	_____
Does your child use a fluoride mouthrinse?	_____	_____
Do you give your child any other form of fluoride?	_____	_____
Does your child participate in a school fluoride rinse program?	_____	_____

Pediatric Consent for Dental Treatment

To the best of my knowledge, the answers I have given are accurate. I agree to report any changes to my child's medical or dental status. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment. I request and authorize Dr. Huel Harris, DMD, (and staff at the doctor's direction) to clean, and provide dental treatment on my child's teeth. I further request and authorize the dentist to take the necessary dental x-rays needed to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. The dentist will provide an environment dedicated to help children learn to cooperate during treatment by using praise, explanation/demonstration of procedures, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment. I understand that my signature shall remain on file and I give my permission to Huel Harris Pediatric Dentistry to file my dental insurance claims on my behalf.

Signature _____ **Date** _____

Insurance Information

Name of Insured _____

Relationship to Patient _____

Date of Birth _____ Date Employed _____

SSC# _____

Employer _____

Work Phone _____

Insurance Company _____ Group # _____

Insurance Phone _____

Financial Responsibility

Payment is due at the time of service. We accept cash, debit cards, VISA, Mastercard, Discover and Care Credit as means of payment. As a courtesy, if you have dental insurance, we will file it for you. We encourage you to become familiar with the limitations of your dental plan (i.e. coverage, deductibles, frequencies of procedures and co-payments), as we will collect your cost share the day of service. To avoid broken appointments, we request a 24-hour courtesy call to cancel your reservation.

Authorization and Release

To the best of my knowledge, the above information is complete and accurate. It is my responsibility to inform Huel Harris Pediatric Dentistry of any changes in my personal information (i.e. telephone number, address, insurance carrier, and/or health). I understand that I am financially responsible for all charges, whether paid by insurance or not, at the time services are rendered. I authorize the use of my signature and authorize this office to submit claims and assign benefits on my behalf to _____ Insurance Company. Huel Harris Pediatric Dentistry may use my health care information and may disclose information to my Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Parent or Legal Guardian _____ **Date** _____

Signature of Treating Dentist or Witness _____ **Date** _____