Rowlett Dental Associates, L.L.P.

4518 Rowlett Rd. • Rowlett, TX 75030-1490 • (972) 475-0301

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us-we will be happy to help.

Child's Name: _____ Child's Age: _____

Gender: _____ Nickname: _____ Child's favorites (pet,toy, friend) _____

Birthdate: _____

Address: _____

Street Apartment #

_____

City State Zip Code

How did you hear about our practice? _____

Please list names and ages of siblings: _____

Parents: ❑ Married ❑ Divorced ❑ Separated ❑ Mother's Name _____ ❑ Father's Name _____

Responsible Party

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____

Email: _____ Cell Phone: _____

Driver's License # _____ Birthdate: _____

Employer: _____ Work Phone: _____ SS#/SIN: _____

Is this person currently a patient in our office? ❑ Yes ❑ No

Dental Insurance Information

Name of Insured: _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group# _____ Policy/ID# _____

Insurance Company Phone Number: _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ❑ Yes ❑ No

If yes, ask us for information on how to file secondary claim

Is there anything that we should know to help make your child's dental visit easier? (sensory issues, past bad experience, etc): _____

_____

_____

_____

_____

_____

Health History

Name of Physician _____ Telephone Number _____

Date of most recent medical examination _____ Child's Current Weight _____

Does the child have or ever had any of the following diseases, medical conditions, or procedures? Please check those that apply: (By checking "NONE" you agree that you have read ALL conditions and that NO conditions currently apply to the child.)

- ❑ Allergies Environmental
- ❑ Allergic to Medication
- ❑ Allergies to Food/Dye
- ❑ Aids/HIV/ARC
- ❑ Anemia
- ❑ Artificial Bones/Joints
- ❑ Asthma or Lung Problems
- ❑ Autism
- ❑ Birth Defects _____
- ❑ Cancer/Tumors
- ❑ Cerebral Palsy
- ❑ Cleft Lip/Palate
- ❑ Codeine Allergy
- ❑ Diabetes
- ❑ Difficulty with Speech
- ❑ Epilepsy/Seizures
- ❑ Excessive Bleeding
- ❑ Head Injuries
- ❑ Hearing Problems
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis (A,B,C)
- ❑ High Blood Pressure
- ❑ Hospitalization/Surgery
- ❑ Hyperactivity/ADHD/ADD
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Latex Allergy
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Mouth Injuries
- ❑ Penicillin Allergy
- ❑ Prolonged Bleeding
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Sickle Cell Trait
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Tuberculosis TB
- ❑ Ulcers
- ❑ Other

Please explain any checked responses...

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

❑ None

List all current medications: _____

List any allergic reactions to medications: _____

List any past surgicial history: _____

List any problems with anesthesia?: _____

List any family history of problems with anesthesia?: _____

Do you consider your child to be: ❑ Advanced in the learning process ❑ Progressing normally ❑ Slow in the learning process

YES NO **Female patients only**: Due to medications we may prescribe, it is important to know if the patient is taking any contraceptives.

YES NO **Female patients only**: Due to x-rays taken, it is important to know if the patient is pregnant or if there is ANY possibility that the patient is pregnant.

Dental History

YES NO Has your child ever been to the dentist? Name of dentist _____

Date of last dental visit and x-rays: _____

YES NO Has your child experienced any unfavorable reaction from previous dental care? Please explain: _____

_____

YES NO Does your child suck a finger, thumb, or pacifier? Please elaborate: _____

YES NO Does your child go to bed with anything to eat or drink? If so, what: _____

Please check if your child is having problems with any of the following:

- ❑ Cavities
- ❑ Toothache
- ❑ Jaw Sounds/Pain
- ❑ Sensitive Teeth
- ❑ Trauma
- ❑ Gum Infections
- ❑ Orthodontics
- ❑ Color of Teeth
- ❑ Other: _____

Fluoride History

YES NO Is your home water supply fluoridated?

YES NO Does your child use a fluoride toothpaste?

YES NO Do you give your child any other form of fluoride? Please list: _____

Consent For Dental Treatment

I request and authorize Dr. Pollock to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Pollock 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. I will be responsible for any charges incurred on this child for dental treatment.

Signature of Parent / Legal Guardian _____ Date _____

I give permission for the use of my child's name and picture for in-office promotions, our dental website and other social media, and for dental advertising purposes. (_____ Initials of Parent / Legal Guardian).