Date:_____

# Jennifer Criss, D.D.S., P.A.
# Nacogdoches Pediatric Dentistry

Patient Name_____ Preferred Name_____
Address_____ City_____ State_____
Home Phone_____ Zipcode_____ Gender ☐ Male ☐ Female
Social Security Number_____ Birthdate_____ Age_____

Guardian/Parent _____ Relation to child_____ SS #_____
Employer_____ Work Phone_____ Cell Phone_____
Guardian/Parent_____ Relation to child_____ SS #_____
Employer_____ Work Phone_____ Cell Phone_____

Do you recieve Email or Text Messages? ☐ Yes ☐ No If yes please provide contact information.
Email_____ Cell Phone_____

## Insurance Information

Name of Insured_____ Employer_____
Drivers License #_____ DOB_____ SS #_____
Insurance Carrier_____ ID #_____ Group #_____

**Please present the front desk with the most recent copy of your dental insurance card.**

Who is escorting the patient today?_____ Relationship_____
Who has Legal custody of this patient?_____
How did you hear about our office?_____
What is the reason for your child's visit today?_____
Does this patient attend school? ☐ Yes ☐ No If so what school?_____ Grade_____
Names and ages of Siblings_____
Childs Hobbies, Pets, & Interests_____
Favorite Snack Foods_____
Who is responsible for tooth brushing? _____

## Dental History

☐ Yes ☐ No Has your child ever been to the dentist? Name of dentist and date_____
☐ Yes ☐ No Has your child experienced any unfavorable experiences or reactions to previous dental care?
Explain_____
☐ Yes ☐ No Does your child suck a finger, thumb, or pacifier? _____
☐ Yes ☐ No Is your child having any dental pain? Location of the pain_____
☐ Yes ☐ No Do you use fluoride toothpaste or mouth rinse? _____
☐ Yes ☐ No Is your child active in sports? List _____
Does your child ☐ breast feed, ☐ bottle feed, or use a ☐ Sippy cup? At what age was is discontinued?_____
Please check if your child is having problems with any of the following:

☐ Cavities ☐ Toothache/Pain ☐ Sensitive Teeth
☐ Trauma ☐ Gum Infections ☐ Color of Teeth
☐ Orthodontics/Crowding ☐ Jaw Sounds ☐ Other: Please explain_____

## Consent for Dental Treatment

I request and authorize Dr. Criss & her staff to examine, clean, and provide dental treatment on my child's teeth. I further request & authorize the taking of dental x-rays as may be necessary by Dr. Criss 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 & 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. Dr. Criss & her staff will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation, demonstration of procedures, instruments, using variable voice tone. I will be responsible for any changes incurred on this child for dental treatment. I understand that the estimated portion of the treatment amount IS DUE at the time of service and that any amount left unpaid by insurance is my responsibility to pay within 60 days. I hereby authorize payment of dental insurance benefits, if any, to be made directly to Jennifer Criss, DDS, PA, dba Nacogdoches Pediatric Dentistry.
**Form will also be signed electronically.**

**Signature** _____ **Date** _____

I give my permission for the following adults to accompany my child to future dental appointments & make treatment decisions concerning my child when I am not present.

Name_____ Phone #_____ Relationship_____
Name_____ Phone #_____ Relationship_____
Name_____ Phone #_____ Relationship_____
Name_____ Phone #_____ Relationship_____

Time 1:27 PM

Nacogdoches Pediatric Dentistry

Date 6/2/2014

**Pediatric Medical History**

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that your child may have, or medication that they may be taking, could have an important interrelationship with the dentistry they will receive. Thank you for answering the following questions.

| | | |
|---|---|---|
| Does your child have a Physician? List the name and the last visit. | ○ Yes ○ No | If yes |
| Has your child you ever been hospitalized or had a major operation? List surgery and dates. | ○ Yes ○ No | If yes |
| Is your child taking any medication? Please include over the counter medications and vitimins. | ○ Yes ○ No | If yes |
| Has your child been diagnosed with a Behavioral or Attention Disorder? List Diagnosis. | ○ Yes ○ No | If yes |
| Have you been told your child needs to take antibiotics prior to dental work? | ○ Yes ○ No | |
| Does your child have a congential heart defect or heart murmur? List Diagnosis. | ○ Yes ○ No | If yes |
| Were there any problems during the mother's pregnancy or during your child's birth? List | ○ Yes ○ No | If yes |
| Has your child ever taken Fosamax, Boniva, Actonel or any other medications for bone loss/cancer? | ○ Yes ○ No | If yes |
| Female patients. Has your child started mensus? | ○ Yes ○ No | If yes |
| Is your child have food allergies or on a special diet? List | ○ Yes ○ No | If yes |

Is your child allergic to any of the following?

| | | | |
|---|---|---|---|
| ☐ Aspirin/Motrin | ☐ Penicillin/Amoxicillin | ☐ Codeine | ☐ Latex/Bandaids |
| ☐ Sulfa Drugs | ☐ Local Anesthetics | ☐ Dyes/Food Coloring | ☐ Sedative Drugs |
| ☐ General Anesthesia | ☐ Peanut | ☐ Tree Nut | ☐ Other |

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Anemia | ○ Yes ○ No | Artificial Heart Valve | ○ Yes ○ No | Blood Disease | ○ Yes ○ No | Blood Transfusion | ○ Yes ○ No |
| Bruises Easily | ○ Yes ○ No | Congenital Heart Disease | ○ Yes ○ No | Excessive Bleeding | ○ Yes ○ No | Heart Murmur | ○ Yes ○ No |
| Pace Maker | ○ Yes ○ No | Heart Trouble/Disease | ○ Yes ○ No | Hemophilia | ○ Yes ○ No | High Blood Pressure | ○ Yes ○ No |
| High Cholesterol | ○ Yes ○ No | Irregular Heartbeat | ○ Yes ○ No | Low Blood Pressure | ○ Yes ○ No | Rheumatic Fever | ○ Yes ○ No |
| Sickle Cell Disease/Trait | ○ Yes ○ No | Stroke | ○ Yes ○ No | Arthritis/Gout | ○ Yes ○ No | Diabetes | ○ Yes ○ No |
| Epilepsy or Seizures | ○ Yes ○ No | Fainting Spells/Dizziness | ○ Yes ○ No | Frequent Headaches | ○ Yes ○ No | Hydrocephalus | ○ Yes ○ No |
| Hypo/Hyperglycemia | ○ Yes ○ No | Kidney Problems | ○ Yes ○ No | Liver Disease | ○ Yes ○ No | Renal Dialysis | ○ Yes ○ No |
| Spina Bifida | ○ Yes ○ No | Thyroid Disease | ○ Yes ○ No | VP Shunt | ○ Yes ○ No | Allergies | ○ Yes ○ No |
| Anaphylaxis | ○ Yes ○ No | Asthma | ○ Yes ○ No | Breathing Problems | ○ Yes ○ No | Frequent Cough | ○ Yes ○ No |
| Hearing Loss/Speech | ○ Yes ○ No | Hives or Rash | ○ Yes ○ No | Lung Disease | ○ Yes ○ No | Sinus Trouble | ○ Yes ○ No |
| Sleep Apnea | ○ Yes ○ No | Snoring | ○ Yes ○ No | Tonsillitis | ○ Yes ○ No | Tooth Grinding | ○ Yes ○ No |
| Tuberculosis | ○ Yes ○ No | Tubes/Ear Infections | ○ Yes ○ No | Vision Problems/Glasses | ○ Yes ○ No | ADHD/ADD | ○ Yes ○ No |
| Autism Specturm Disorder | ○ Yes ○ No | Bipolar Disorder | ○ Yes ○ No | Cerebral Palsy | ○ Yes ○ No | Cleft Lip/Cleft Palate | ○ Yes ○ No |
| Congenital Birth Defects | ○ Yes ○ No | Cortisone Medicine/Steroids | ○ Yes ○ No | Developmental Delays | ○ Yes ○ No | Drug Addiction | ○ Yes ○ No |
| Genetic Disorder | ○ Yes ○ No | Physical Delays | ○ Yes ○ No | Psychiatric Care | ○ Yes ○ No | Trisomy 21/Down Syndrome | ○ Yes ○ No |
| Tuberous Sclerosis | ○ Yes ○ No | Acid Reflux | ○ Yes ○ No | Feeding Tube | ○ Yes ○ No | Frequent Diarrhea | ○ Yes ○ No |
| Recent Weight Loss/Gain | ○ Yes ○ No | Stomach/Intestinal Disease | ○ Yes ○ No | Ulcers | ○ Yes ○ No | AIDS/HIV Positive | ○ Yes ○ No |
| Artifical Joint/Screws/Plates | ○ Yes ○ No | Cancer | ○ Yes ○ No | Chemotherapy | ○ Yes ○ No | Cold Sores/Fever Blisters | ○ Yes ○ No |
| Hepatitis A | ○ Yes ○ No | Hepatitis B or C | ○ Yes ○ No | Leukemia | ○ Yes ○ No | Radiation Treatments | ○ Yes ○ No |
| Shingles | ○ Yes ○ No | STD/Veneral Disease | ○ Yes ○ No | Swelling of Limbs | ○ Yes ○ No | Tumors or Growths | ○ Yes ○ No |
| Thrush | ○ Yes ○ No | | | | | | |

| | | |
|---|---|---|
| Are there any symptoms not listed above if so please elaborate on the above conditions. | ○ Yes ○ No | If yes |
| Has your child had any conditions not listed above? Please List | ○ Yes ○ No | If yes |

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 medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____