CHILDREN'S DENTAL CENTER
DANIEL SEETIN DDS PLLC
PEDIATRIC DENTISTRY

PATIENT INFORMATION

Childs Last Name	First	Middle	Nickname	Sex M F	Date of Birth	Age

Child's Address (Street)	City	State	Zip Code	Phone

Child's School/Preschool	Grade

Parent's Full Name	Relationship to Child	Parent's Full Name	Relationship to Child

Address	Address

City	State	Zip	City	State	Zip

Home Phone	Work Phone	Home Phone	Work Phone

Occupation	Occupation

Name of Employer	Name of Employer

Years with this Employer	Years with this Employer

Dental Insurance Company	Dental Insurance Company

Social Security Number	Social Security Number

Group #	Date of Birth	Group #	Date of Birth

Driver's License Number	Driver's License Number

Do both Parents and Child all live together? (If No, Please explain)	

If Parents cannot be reached, Friend or Relative to Notify should an emergency arise. Name Relationship	Phone

Has any member of your family been a patient in this office ☐ YES ☐ NO	Name of Siblings	Is patient covered by Public Assistance Coupons? ☐ YES ☐ NO

Family's General Dentist	Date of Child's last exam and cleaning and name of Dentist

Consent and Assignment for the Treatment of a Minor

The undersigned hereby authorizes Dr. Daniel Seetin (Children's Dental Center) to perform the examination and, after explanation, the necessary dental services and those methods he deems appropriate in his professional judgment for the care of the above-named child. This authorization includes the release of my child's medical records if deemed necessary for the proper care of my child. I further authorize that my insurance benefits be paid directly to the dentist and I understand that I am financially responsible to the dentist for all the charges not covered by my insurance. The consent shall remain in full force and effect until cancelled by either party.

Signature _____ **Date**_____

_____

Relationship to Child

PLEASE COMPLETE BOTH SIDES

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MEDICAL AND DENTAL HISTORY

Childs Last Name	First	Middle	Nickname	Date of Birth	Age

	Yes	No
1. Has child ever been examined by another dentist? _____	☐	☐
Previous dentist _____ Date _____		
2. Has child complained about dental problems? _____	☐	☐
3. Any unhappy dental experiences_____	☐	☐
4. Any injuries to mouth, teeth, head? _____	☐	☐
5. Any mouth habits – thumb sucking, nail biting, mouth Breathing, nursing bottle habits, pacifier, etc? _____	☐	☐
6. Any unusual speech habits?_____	☐	☐
7. Any missing or extra teeth? _____	☐	☐
8. Have missing teeth been replaced? _____	☐	☐
9. Orthodontic appliances or braces worn now or ever Been worn? _____	☐	☐
10. Unfavorable reaction to anesthesia? _____	☐	☐

	Yes	No
1. Purpose of this visit _____		
2. Do you desire complete dental services for the child? _____	☐	☐
3. Child's attitude to dentistry _____		
☐ Normal ☐ Shy ☐ Apprehensive ☐ Frightened		
4. Does your child brush teeth daily? _____	☐	☐
5. Do you assist child with tooth brushing? _____	☐	☐
6. Is dental floss used? _____	☐	☐
How often? _____		
7. Are disclosing tablets used? _____	☐	☐
8. Is fluoride taken? _____	☐	☐

Child's Physician **Address** **Phone**

Date of Last Physical Examination **Results**

	Yes	No
1. Is child under care of physician now? _____	☐	☐
2. Is child receiving any medication or drugs? _____	☐	☐
What?_____		
3. Is there any excessive bleeding when cut? _____	☐	☐
4. Has child ever been hospitalized? _____	☐	☐
5. Has child ever had surgery? _____	☐	☐
6. Is there any allergy to penicillin or other drugs? _____	☐	☐

	Yes	No
7. Are there other allergies: food, animals, dust , latex? ___	☐	☐
8. Does child have physical coordination problems?_____	☐	☐
9. Are there any emotional problems? _____	☐	☐
10. Are your child's vaccinations up to date? _____	☐	☐
11. Has your child ever had a blood transfusion? _____	☐	☐
12. Is your child adopted?_____	☐	☐
Does he/she know?_____	☐	☐

HAS YOUR CHILD HAD ANY HISTORY OF, OR DIFFICULTY WITH ANY OF THE FOLLOWING?

☐ Heart	☐ Bladder	☐ Chronic Sinus	☐ Epilepsy	☐ Hearing	☐ Liver	☐ Rheumatic Fever	
☐ Anemia	☐ Bleeding disorders	☐ Convulsions	☐ Ear Aches	☐ Hepatitis	☐ Malignancies	☐ Thyroid	☐ Aids/HIV
☐ Asthma	☐ Cerebral Palsy	☐ Diabetes	☐ Fainting	☐ Kidney	☐ Mononucleosis	☐ Tuberculosis	☐ Other

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed _____

I CERTIFY THAT I AM THE DULY AUTHORIZED AGENT OF THE PATIENT AND THAT I HAVE READ AND I UNDERSTAND THE ABOVE QUESTIONS. I WILL NOT HOLD DR. DANIEL SEETIN, HIS ASSOCIATES, OR ANY MEMBER OF HIS STAFF, RESPONSIBLE FOR ANY ERRORS OR OMMISIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE_____ **DATE**_____

RELATIONSHIP TO CHILD _____

PLEASE COMPLETE BOTH SIDES