Welcome

THE PASS pediatric dental group

Dr. Meghanne Kruizenga
D.D.S., M.S.D.

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell us about your child

Today's Date	SS#
Child 's Name	
Birthdate	Child's Age:
Nickname	❑ Male ❑ Female
School	Grade
Hobbies	
Home Address	Apt#
City, State, Zip	
Home Phone	

General Information

Who is accompanying the child today?	
Name	Relation
Do you have legal custody of this child? ❑ Yes ❑ No	
Whom may we thank for referring you?	
Other Siblings	
Previous/Present Dentist	Date of Last Visit
Dentist's Phone#	
Relative or Friend not living with you?	
Name	Phone Number

Parent's Information

Person responsible for Account — Parent's Marital Status ❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Divorced ❑ Separated

Name	DOB	Name	DOB
Choose One: ❑ Father ❑ Step Father ❑ Guardian		Choose One: ❑ Mother ❑ Step Mother ❑ Guardian	
Address (If different than Child's)	Home Phone	Address (If different than Child's)	Home Phone
City, State, Zip		City, State, Zip	
SS#	DL#	SS#	DL#
Work Ph	Cell#	Work Ph	Cell#
Email Address		Email Address	
Employer's Name		Employer's Name	
Address		Address	
City, State, Zip		City, State, Zip	
If you have Dental Insurance for the child, please fill out below		If you have Dental Insurance for the child, please fill out below	
Insurer's Name		Insurer's Name	
Address		Address	
Phone	Group#	Phone	Group#

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www.passpediatricdental.com

Dental History

Why did you bring the child to the dentist today?

Has the child ever taken any diet pills such as Phen-Fen? ❑ YES ❑ NO

(Also known as Redux or Pondimin) If so, when?

Is the child currently in pain ❑ YES ❑ NO

Does the child require antibiotics before dental treatment? ❑ YES ❑ NO

Has the child ever had a serious/difficult problem associated with previous dental work? ❑ YES ❑ NO

Is the child's water fluoridated? ❑ YES ❑ NO

Is the child taking fluoridated supplements? ❑ YES ❑ NO

Has the child ever had any pain tenderness in his/her jaw joint (TMJ/TD)? ❑ YES ❑ NO

Does the child brush his/her teeth daily? ❑ YES ❑ NO

Floss his/her teeth daily? ❑ YES ❑ NO

Child's Physician

Physician's Ph #

Date of last visit

Is the child currently under the care of a physician ❑ YES ❑ NO

Please describe the child's current physical health ❑ Good ❑ Poor

Please list all prescription I over the counter or herbal supplement drugs that the child is currently taking.

Aside from items listed, please list all drugs I that the child is allergic to

Latex: ❑ YES ❑ NO Metals/Nickel: ❑ YES ❑ NO Plastic: ❑ YES ❑ NO

Medical History

Abnormal Bleeding	❑ YES ❑ NO	Hemophila y N Heart Murmur	❑ YES ❑ NO
ADD/ADHD	❑ YES ❑ NO	Hepatitis	❑ YES ❑ NO
AIDS / HIV Positive	❑ YES ❑ NO	High Blood Pressure	❑ YES ❑ NO
Anemia	❑ YES ❑ NO	Hives	❑ YES ❑ NO
Any Hospital Stays / Operations?	❑ YES ❑ NO	Kidney Problems	❑ YES ❑ NO
Artificial Bones/Joints/Valves	❑ YES ❑ NO	Liver Problems	❑ YES ❑ NO
Asthma	❑ YES ❑ NO	Low Blood Pressure	❑ YES ❑ NO
Cancer	❑ YES ❑ NO	Lupus	❑ YES ❑ NO
Chicken Pox	❑ YES ❑ NO	Measles	❑ YES ❑ NO
Congenital Heart Defect	❑ YES ❑ NO	Mitral Valve Prolapse	❑ YES ❑ NO
Convulsions	❑ YES ❑ NO	Mononucleosis	❑ YES ❑ NO
Diabetes	❑ YES ❑ NO	Prosthetics	❑ YES ❑ NO
Exposed to HIV, but Negative	❑ YES ❑ NO	Rheumatic Fever	❑ YES ❑ NO
Epilepsy	❑ YES ❑ NO	Scarlet Fever	❑ YES ❑ NO
Handicaps/Disabilities	❑ YES ❑ NO	Skin Rash	❑ YES ❑ NO
Hearing Impairment	❑ YES ❑ NO	Tuberculosis	❑ YES ❑ NO

Are the child's immunizations current? ❑ YES ❑ NO

Anything you would like to discuss with Doctor in private? ❑ YES ❑ NO

Please discuss any serious medical problems the child experiences/ed:

Does I did the child experience any of the following?

Breast Fed	❑ YES ❑ NO	Nursing Bottle Habits	❑ YES ❑ NO
Chewing on objects	❑ YES ❑ NO	Speech problems	❑ YES ❑ NO
Clenching/grinding teeth	❑ YES ❑ NO	Thumb / finger sucking	❑ YES ❑ NO
Lip sucking or biting	❑ YES ❑ NO	Tongue / cheek biting	❑ YES ❑ NO
Mouth breather	❑ YES ❑ NO	Tongue thrust	❑ YES ❑ NO
Nail biting	❑ YES ❑ NO	Used a pacifier	❑ YES ❑ NO

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection mondated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian _____ Date_____

OFFICE USE ONLY ~ OFFICE USE ONLY ~ OFFICE USE ONLY ~ OFFICE USE ONLY

I have verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Signature of Dentist _____ Date_____

Dentist's Comments _____

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