Jacob Lee, DDS, FAAPD
Aaron Lee, DDS
Diplomates of the American Board of Pediatric Dentists
Specialists in Dentistry for Infants, Children, and Young Adults

Welcome

Date:_____ Email Reminders ok? Y N Email address:_____

Patient:_____
Last name First Name M.I. Preferred Name

Address:_____
Street City State Zip

Mom's Cell:_____ Dad's Cell: _____ Home Phone:_____

Preferred call #? Home MCell DCell Text Reminders ok? Y N

Sex: M F Age:_____ Birthdate:_____ School:_____ Grade:_____

Mother's Name_____
Last name First Name M.I. Soc Sec #

Father's Name_____
Last name First Name M.I. Soc Sec #

To whom may we thank for referring you?_____

Alternate/Additional Contact Name:_____ Relation to patient:_____

Home Phone: _____ Work/Cell:_____

Primary Insurance

Person Responsible for Account:_____

Relation to the Patient:_____ Birthdate:_____ Soc. Sec. #_____

Address:_____
(If different from above) Street City State Zip

Telephone #_____ Employer:_____ Occupation:_____

Insurance Company:_____ Phone #:_____

Group #:_____ Subscriber ID #:_____

Do you have any additional dental insurance? Yes No

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Medical History

Child's Name:_____ DOB:_____

Child's Physician:_____ Phone #_____

1. Does your child have any health problems? Yes No
2. Has your child ever been hospitalized? Yes No
   a. If "yes", when and why_____
3. List medications your child is taking, if any:_____
4. List drug allergies, if any:_____
5. Is immunization current? Yes No
6. Has your child had any history of the following:

____AIDS/HIX Positive	____Cough up Blood	____Kidney disease or malfunction	____Skin rash
____Anemia	____Diabetes	____Liver Disease	____Spina Bifida
____Asthma	____Fainting	____Material allergies (ie. latex,	____Thyroid
____Blood Disease	____Food Allergies	wool, metal, chemicals)	disease/malfunction
____Cancer	____Headaches/Migraines	____Respiratory disease	____Tonsillitis
____Chicken Pox	____Hearing Impairment	____Rheumatic/Scarlet Fever	____Tuberculosis
____Convulsions/Epilepsy	____Heart Problems	____Shortness of breath	____Other
____Cough/Persistent	____Hemophilia/Abnormal Bleeding	____Sinus Problems	

Describe in detail any of the above problems:_____

_____

Dental History

What would you like to do for your child today?_____

Former Dentist_____ Address_____ Phone_____

Date of last dental care_____ Date of last x-rays_____

How often does your child brush?_____

Does your child ever experience pain or discomfort in the jaw joint? Yes No

Has your child ever experienced a mouth or chin injury? Yes No

Does your child have speech problems?

_____

Has your child ever experienced an adverse reaction

or in conjunction with a medical or dental procedure? Yes No

Child's habits affecting the mouth or teeth: ____Thumb Sucking ____Nail Biting Other_____

Other information about your child's dental health or previous treatment_____

_____

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist as soon as possible.
I authorize the insurance company indicated on this form to pay to Cow Camp Dentistry all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.

[ ] I understand that I am financially responsible for all charges whether or not they are paid by insurance.

Initial Here

Signature_____ **Date:**_____

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRAGEMENTS HAVE BEEN APPROVED.