Welcome to our office
Helena Urrea-Feldsberg DDS, MDS.
Pediatric Dentist

Patient's Name: _____Nickname:_____Date_____
Last First

Birth Date____/____/_____ Age_____ Sex_____ School: _____Grade:_____

Child's Home Address: _____
Street City State Zip

Childs's Home Phone #: (___) _____ Other Siblings: (Ages) _____

Who Does the child live with?_____Is child in a foster home?_____ Is your child adopted?_____

Whom may we thank for referring you?_____Child's Primary spoken language:_____

What is the reason for today's visit:_____

Parent's Information

Person responsible for account:_____Relationship to Patient:_____

Parent's Marital Status: ___Married ___Divorced ___Separated ___Widowed ___Remarried ___Single ___Partnered

Mother's Full Name:_____ Birth Date____/____/_____

Address (If different from child**):_____**

Social Security #_____Driver's License #:_____

Occupation: _____Employer:_____ Business Phone #: (___) _____

Cell or Pager #: (___) _____Fax#: (___) _____ Email: _____

Father's Full Name: _____ Birth Date____/____/_____

Address (If different from child**):_____**

Social Security #_____Driver's License #:_____

Occupation: _____Employer:_____ Business Phone #: (___) _____

Cell or Pager #: (___) _____Fax#: (___) _____ Email: _____

In case of emergency contact:_____

Dental Insurance Information

Primary Policy Holder: **Name:_____**
SS#:_____

Insurance Carrier: **Name:_____**
Address:_____
_____

Group/Policy Number: _____

Employer of Insured: **Name:_____**
Address:_____
_____

Patient ID Number: _____

I assign the Doctor all insurance benefits. I understand that I'm responsible for payment of services rendered, any deductible and co-payment that my insurance does not cover.

_____ _____
Parent/Guardian **Date**

Medical History

Name of Child's Physician:_____Phone #: (___) _____

Is your child in good health? Yes No
Is your child taking any medication? (list below) Yes No
Is your child sensitive/allergic to any medication? (list below) Yes No
Is your child sensitive/allergic to any foods?(list below) Yes No
Is your child sensitive/allergic to Latex? Yes No
Does your child bruise easily? Yes No
Does your child bleed excessively when cut? Yes No
Was your child ever hospitalized or had surgery? Yes No
If yes, when:_____ Why:_____
Ever been treated at the hospital emergency room? Yes No
If yes, when:_____ Why:_____
Are immunizations current? Yes No
Does your child have (or had) any of the following conditions? If yes, state when diagnosed:

Cancer	Yes	No	Liver disease	Yes	No
ADD/ADHD	Yes	No	Kidney disease	Yes	No
Developmental disability	Yes	No	Tuberculosis (or exposure)	Yes	No
Cerebral Palsy	Yes	No	Hepatitis A, B or C	Yes	No
Seizures	Yes	No	AIDS/HIV positive	Yes	No
Anemia	Yes	No	Auto Immune disorder	Yes	No
Rheumatic fever	Yes	No	Blood disorder	Yes	No
Allergies	Yes	No	Hearing difficulty	Yes	No
Asthma (or Reactive Airway Disease)	Yes	No	Speech problems	Yes	No
Diabetes	Yes	No	Frequent colds	Yes	No
Digestive disorders	Yes	No	Frequent ear infections	Yes	No
Heart disease or defects	Yes	No	Pregnant	Yes	No
Heart murmur	Yes	No			

Any other condition not listed above: _____
List current medications: _____
Why: _____
List medications allergic/sensitive to: _____
List food allergic/sensitive to: _____

Additional Comments or Remarks: _____

Diet History

How many meals does your child eat per day? _____
How many snacks does your child eat per day? _____
List three of your child's favorite snacks _____
Was your child breast fed? Yes No
Age started: _____ Age stopped: _____
Was your child bottle fed? Yes No
Age started: _____ Age stopped: _____
If bottle fed, the bottle usually contained: _____
Was your child allowed to fall asleep with bottle? Yes No
Were teeth cleaned after naptime/nighttime feedings? Yes No

Dental History

Has your child been to the dentist before? Yes No

If yes, does your child go regularly? Yes No Last visit _____

Were x-rays taken? Yes No Date_____

Dentist's name _____ **Phone #: (___) _____**

Address_____

Comments_____

Has your child ever had a toothache? Yes No

Is your child nervous about this visit? Yes No

Is there fluoride in your drinking water? Yes No

Does your child take a fluoride supplement? Yes No

If yes, what: _____ Who prescribed: _____When: _____

Does your child brush his/her own teeth? Yes No

Do you help your child brush? Yes No

Does your child use dental floss? Yes No

Has your child injured their teeth? Yes No

If yes, explain: _____

Is there a history of tooth decay in the family? Yes No

If yes, explain: _____

Does (or did) your child have any of the following habits? (please check)

___Clenching or grinding teeth ___Finger or thumb habit

___Mouth breathing ___Pacifier

I certify that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my child's medical status.

_____ _____ _____

Signature **Relation to patient** **Date**

_____ _____

Doctor Signature **Date**

CONSENT FOR DENTAL TREATMENT

I authorize DR. HELENA URREA-FELDSBERG and her staff to examine, clean and provide my child with comprehensive dental treatment including fillings, crowns and extractions if required. I authorize the taking of dental X-rays as may be considered necessary by Dr. URREA-FELDSBERG to diagnose and/or to treat my child's dental condition. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic purpose. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Urrea-Feldsberg will provide an environment likely to help children to learn to cooperate during treatment by using praise, explanation and demonstration procedures and instruments, and using variable voice tone.

Parent_____Date_____