Thomas G. Wilson, D.D.S., P.C.
Pediatric Dentist/Orthodontist
Denise N. Evans, D.D.S.
Pediatric Dentist

515-278-2333

www.dmkidsdds.com

Date _____

Patient Information

Last Name _____ First Name _____ Middle Initial _____ Sex _____

Prefers to be Addressed By _____ Date of Birth ____/____/____ Age (years) _____

Address _____ Apt # _____

City _____ State _____ Zip _____ Preferred Contact Phone _____

Other family members treated at this office _____

Parental Information

Circle One: Mother, Stepmother, Guardian	Circle One: Father, Stepfather, Guardian
Name _____	Name _____
Date of Birth _____	Date of Birth _____
Social Security # _____	Social Security # _____
E-mail Address _____	E-mail Address _____
Cell Phone _____	Cell Phone _____
Does Patient Live With You? _____	Does Patient Live With You? _____
Employer _____	Employer _____
Employer Address _____	Employer Address _____
Work Phone _____	Work Phone _____
Complete if DIFFERENT from patient's home information:	Complete if DIFFERENT from patient's home information:
Home Address _____	Home Address _____
City _____ State ____ Zip _____	City _____ State ____ Zip _____
Home Telephone _____	Home Telephone _____

Dental Insurance Information

(Please provide your insurance card to the receptionist)

Primary Insurance	Secondary Insurance
Company _____	Company _____
Address _____	Address _____
City _____ State ____ Zip _____	City _____ State ____ Zip _____
Insurance Telephone _____	Insurance Telephone _____
ID # _____	ID # _____
Policy Holder's Name _____	Policy Holder's Name _____
Relationship to Patient _____	Relationship to Patient _____

Please keep in mind that you are ultimately responsible for payment on your account. If your insurance does not pay the claim, you are responsible for the outstanding balance. Insurance is a contract between *you and the insurance company, not our office.*

DENTAL HISTORY

1. Previous dentist (if any) _____ Date of last dental exam _____
2. When, if ever, were x-rays taken? _____
3. Has your child had any unfavorable dental experiences? _____
4. Has your child been treated with Nitrous Oxide? (laughing gas) _____ Lidocaine? (local anesthetic) _____
5. Current Mouth Habits (Please Check): ☐ Thumb sucking ☐ Pacifier ☐ Mouth breathing ☐ Finger habit ☐ Tooth grinding ☐ Other _____
6. How often does your child brush? _____ Floss? _____
7. Is there parental supervision? _____ Brushing? _____ Flossing? _____
8. Does your child drink fluoridated water? _____
9. Does your child use any fluoridated supplements? (rinses, vitamins)? _____
10. Is your child still nursing? _____ Taking a bottle? _____
11. Does your child have a specific dental problem that needs to be addressed? _____
    If so, explain _____
12. Has your child had trauma to the mouth/teeth?
    If so, explain _____

MEDICAL HISTORY

1. Is your child's general health good at this time? ☐ Yes ☐ No
2. Name of physician? _____ Date of last physical: _____
3. Is your child under the care of a physician at this time? ☐ Yes ☐ No
    If yes, explain: _____
4. Is your child taking any medication? ☐ Yes ☐ No
    If yes, Medicine & reason for: _____
5. Is your child allergic to any medication? (Penicillin, Sulfa, etc.) ☐ Yes ☐ No
    If yes, what: _____
6. Does your child have any allergies? (metals or seasonal) ☐ Yes ☐ No
    If yes, what: _____
7. Does your child have any food allergies? _____
8. Has your child had tonsils and adenoids removed? ☐ Yes ☐ No Date: _____
9. Has your child ever had a serious illness or been hospitalized? ☐ Yes ☐ No Date: _____
    If yes, explain: _____
10. Has your child ever been advised by their physician to take on antibiotic prior to any dental treatment? ☐ Yes ☐ No
    If yes, Antibiotic name & dose: _____

Please Check all conditions your child has now or has had previously

_____ Carries rescue inhaler	_____ Carries epi pen for allergy	_____ Speech Impairment
_____ Heart condition, if yes, specify	_____ Kidney problems	_____ Sinusitis
_____ Hepatitis (type _____)	_____ Liver disease	_____ Headaches/migraines
_____ Has insulin pump	_____ AIDS or H.I.V. positive	_____ Cleft palate/lip
_____ Diabetes	_____ Prosthetic (artificial) joint	_____ Spina bifida
_____ Tuberculosis	_____ Radiation therapy (cancer)	_____ Scoliosis
_____ Blood disorders/bleeding problems	_____ Autistic	_____ Latex allergy
_____ Sickle cell	_____ Mentally handicapped	_____ Emotional anxiety
_____ Asthma	_____ ADD/ADHD	_____ Other _____
_____ Epilepsy (seizures)	_____ Gluten intolerance/celiac disease	_____

I certify that the information given is correct and give consent to treat my child.

Signature: _____ Date _____

(Please Circle One) PARENT GUARDIAN OTHER

Reviewed by _____ Date _____