PECKOSH PEDIATRIC DENTISTRY, P.C.
Dr. Valerie Peckosh
Dr. Kayla Risma

We are pleased to welcome you and your child to our practice.
Please fill out form completely. All information is confidential.

Patient Information

Child's Name:_____________________________Referred By:___________
Nickname:___________Child's Age:___ Birthday:_________ Sex: (M) (F)
Race:____________Child's SSN:_____________ School:______________
Address:__________________City:_____________State:_____Zip:______
Home #________________Work #_________________Cell #______________
Child lives with: Both Parents Mother Father Other
Name & age of Siblings:____
Child's Interests, Hobbies or Pets:____________________________________
Purpose of Visit:____
Emergency Contact & relationship:__________________Phone#__________

General Information

Mother Father Stepmother Stepfather Guardian

Name:______________________SS#:_______________D.O.B.__________
Address:____________________City:__________State:_______Zip:______
Home #________________Work #__________________Cell #____________
Employer: ____

Mother Father Stepmother Stepfather Guardian

Name:_______________________SS#:______________D.O.B.__________
Address:____________________City:___________State:______Zip:______
Home #__________________ Work #________________Cell #___________
Employer:____

Dental Insurance Information

Subscriber:_____________________Subscriber #______________Gr#_____
Insurance Comp Name:___________________________Phone #__________
Address_______________________City___________State_____Zip______

DENTAL HISTORY

Date of Child's last visit to a Dentist_________What service____________
What is your Child's attitude towards visiting the dentist: Positive Negative
Has your Child complained of dental problems- Yes No – Describe_______
Has your Child had any injury to teeth or head- Yes No – Describe________
Has your Child had any Orthodontic treatment - Yes No – Describe_______
Has your child had any Dental treatment –Yes No if yes what type of anesthesia was used? None- Local Anesthesia-Sedation-General Anes-N2O
Does your child have any mouth habits such as:

Thumb Sucking	Yes No	Nursing Bottle Habits	Yes No
Nail Biting	Yes No	Pacifier	Yes No
Mouth Breathing	Yes No	Speech Habits	Yes No
Finger Sucking	Yes No	Teeth grinding or clenching	Yes No

Does your child brush teeth daily- Yes No
Do you assist with brushing- Yes No
Does your child use dental floss- Yes No   If so when: Daily Sometimes
Is your water fluoridated- Yes No If No, do you have a fluoride RX- Yes No

Medical History

Child's Physician:___________________________Phone#____________
Date of last visit:____Has your child had any illnesses or operations-Yes No
If yes, describe:____
Is your child under physician's care now- Yes No If yes why:____________
Are your child's immunizations current- Yes No
Is your child taking any medications- Yes No List_____________________
Is your child allergic to any medications- Yes No List__________________
Does your child have any allergic reactions- Yes No List_______________
Does your child have a handicap or development problem- Yes No List____
Has your child had any of the following- please circle all that apply:

AIDS/HIV positive	Anemia	Asthma	Cancer
Convulsions/Epilepsy	Cough, persistent	Diabetes	Fainting
Hearing Impairment	Heart Problems	Headaches	Hemophilia
Kidney Problems	Vision Problem	Hepatitis	Acid Reflux
Shortness of breath	Rheumatic Fever	Sinus Problems	Spina Bifida
Respiratory Disease	Heart Murmur	Liver Disease	Skin Rash
Thyroid Disease	Tonsillitis	Tuberculosis	Other_____

I authorize Peckosh Pediatric Dentistry, P.C. to release any information, including the diagnosis records of treatment or examination rendered to my child during the period of such care, to third party payers and/or other health practitioner . I understand that my insurance carrier may pay less then the actual bill for services. I agree to be responsible for payment of all services render on my dependent's behalf. I agree to be responsible for all fee incurred. **Payments of deductibles , copay and any non-covered charges are due at each appointment.**
Parent or Guardian's Signature:________________________Date_____
Relationship (if not Parent)____