ALLISON B. ROSE, DMD
BOARD CERTIFIED

COLLEGEVILLE PEDIATRIC DENTISTRY

YOUR CHILD'S PATIENT HISTORY

Welcome to Collegeville Pediatric Dentistry! Thank you for entrusting your child to our care.We are committed to providing the best possible dental assessment and treatment; the first step is to gather detailed information about your child's dental and medical history and needs. Our office policies are in strict compliance with HIPAA (Health Insurance Portability and Accountability Act), which protects patient privacy.

PLEASE TELL US ABOUT YOUR CHILD

TODAY'S DATE ____ / ____ / ____

NAME _____ NICKNAME _____
FIRST LAST MIDDLE INITIAL

BIRTH DATE ____ / ____ / ____ AGE _____ MALE ☐ FEMALE ☐

STREET ADDRESS _____ CITY _____ STATE ____ ZIP _____

HOME PH# _____ FAMILY EMAIL _____

SCHOOL _____ GRADE ____ HOBBY/ SPORT _____

PREVIOUS DENTIST _____ DATE OF LAST VISIT ____ / ____ / ____

HOW DID YOU FIND OUR OFFICE? REFERRED ☐ INTERNET ☐ INSURANCE LISTING ☐ OTHER ☐

PLEASE TELL US ABOUT YOUR FAMILY BACKGROUND

WHO HAS BROUGHT THIS CHILD TO SEE US TODAY?

NAME _____ RELATION _____ DO YOU HAVE LEGAL CUSTODY? YES ☐ NO ☐

PLEASE CHECK ONE
MOTHER ☐ STEP-MOTHER ☐ GUARDIAN ☐

NAME _____

BIRTH DATE ____ / ____ / ____ SS# _____

CELL # _____ WORK # _____

PLEASE CHECK ONE
FATHER ☐ STEP-FATHER ☐ GUARDIAN ☐

NAME _____

BIRTH DATE ____ / ____ / ____ SS# _____

CELL # _____ WORK # _____

PARENT'S MARITAL STATUS SINGLE ☐ MARRIED ☐ PARTNERS ☐ DIVORCED ☐

IS THIS CHILD ADOPTED? YES ☐ NO ☐ IS THIS CHILD LIVING IN A FOSTER HOME? YES ☐ NO ☐

PLEASE TELL US WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

NAME _____ RELATION _____

BILLING ADDRESS _____ CITY _____ STATE ____ ZIP _____

BIRTH DATE ____ / ____ / ____ CELL PH# _____ WORK PH# _____

EMPLOYER _____ INSURANCE CARRIER _____

SUBSCRIBER SS# _____ ID# _____ PLAN GROUP # _____

I certify that my child's treatment is covered by the listed insurance company and I assign this office all insurance benefits that are otherwise payable to me. I understand that I am responsible for payment for services rendered, and also for any co-payment and/ or deductibles that my insurance does not cover. I hereby authorize this office to release all information necessary to secure payment of these benefits. I authorize the use of this signature on all my insurance submissions processed by this office, both manual and electronic.

SIGNATURE _____ DATE ____ / ____ / ____

610.409.2599
www.collegevillepediatricdentistry.com

YOUR CHILD'S DENTAL HEALTH

YOUR CHILD'S GENERAL HEALTH

PLEASE DESCRIBE THIS CHILD'S CURRENT PHYSICAL HEALTH GOOD ☐ FAIR ☐ POOR ☐

IS THIS CHILD'S IMMUNIZATIONS UP TO DATE? YES ☐ NO ☐

IS THIS CHILD TAKING FLUORIDE SUPPLEMENTS? YES ☐ NO ☐

IS THIS CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN? YES ☐ NO ☐

PHYSICIAN'S NAME _____ LAST VISIT _____ / _____ / _____

DOES THIS CHILD CURRENTLY EXPERIENCE:

THUMB, FINGER, OR LIP SUCKING HABIT YES ☐ NO ☐

BOTTLE-USE/ NURSING YES ☐ NO ☐

YOUR CHILD'S MEDICAL HISTORY

DOES THIS CHILD HAVE ANY ALLERGIES? ANTIBIOTICS ☐ METALS ☐ LATEX ☐ FOODS ☐ SEASONAL ☐

IF SO, PLEASE LIST _____

HAS THIS CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL EXPERIENCES?

ABNORMAL BLEEDING	YES ☐	NO ☐	HANDICAPS/ DISABILITIES	YES ☐	NO ☐
ADD/ ADHD	YES ☐	NO ☐	HEARING IMPAIRMENT	YES ☐	NO ☐
ANEMIA	YES ☐	NO ☐	HEART MURMUR	YES ☐	NO ☐
ARTIFICIAL BONES/ VALVES/ ETC	YES ☐	NO ☐	HEMOPHILIA	YES ☐	NO ☐
ASTHMA	YES ☐	NO ☐	HEPATITIS	YES ☐	NO ☐
AUTISM	YES ☐	NO ☐	HIVES/ SKIN RASH	YES ☐	NO ☐
CANCER	YES ☐	NO ☐	KIDNEY/ LIVER ISSUES	YES ☐	NO ☐
CHICKEN POX	YES ☐	NO ☐	MONONUCLEOSIS	YES ☐	NO ☐
CONGENITAL HEART ISSUE	YES ☐	NO ☐	RHEUMATIC FEVER	YES ☐	NO ☐
DIABETES	YES ☐	NO ☐	SICKLE CELL DISEASE	YES ☐	NO ☐
EPILEPSY	YES ☐	NO ☐	SURGICAL OPERATION	YES ☐	NO ☐
EXPOSURE TO HIV/ HIV+	YES ☐	NO ☐	TUBERCULOSIS (TB)	YES ☐	NO ☐

PLEASE DESCRIBE ANY SERIOUS MEDICAL PROBLEM THIS CHILD HAS EXPERIENCED:

_____

PLEASE LIST ANY MEDICATIONS THIS CHILD IS CURRENTLY TAKING:

_____

I declare that the information I have provided is correct to the best of my knowledge, and I understand that it will be held in the strictest confidence. I recognize my responsibility to inform Collegeville Pediatric Dentistry of any changes in my child's medical status as I have described it herein, and I authorize the dental staff of this office to perform the dental services that my child may require.

SIGNATURE _____ DATE _____ / _____ / _____

OFFICE USE ONLY:

I have verbally reviewed the medical and dental information above with the Parent(s) and/or Guardian(s) for the Patient named herein.

SIGNATURE _____ **DATE** _____ / _____ / _____