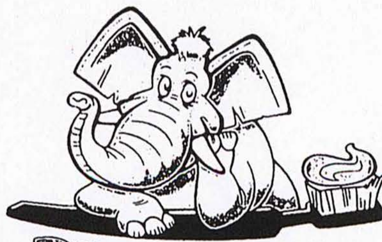
DJUANA CARTILLAR, DDS
PEDIATRIC DENTISTRY SPECIALIST



PDEA Kids
PEDIATRIC DENTISTRY
OF EASTERN ARKANSAS

4850 North Washington/Hwy 1
Forrest City, Arkansas 72335
870-630-1500
www.pdeakids.com

Welcome to our office! Please fill out this form completely in ink

Child's name__________________________Birthdate__________ Sex M F
Name child goes by________________________________
Child's Social Security #______________________________
Hobbies/Pets____________________________________
Home Address____________________________Phone #__________
City______________________ST______ZIP____________Grade____
Names and ages of other children in family____________________
Do parents live together? Y N If not with whom does the child live?__________

Parent/Guardian Information_____Mother______Stepmother______Guardian
Name__________________________DOB__________Occupation__________
Employer________________________Work Phone #__________________
SS#____________________________Cell#______________________
Marital Status M D W S Email address________________________
Parent/Guardian Information_____Father______Stepfather______Guardian
Name__________________________DOB__________Occupation__________
Employer________________________Work Phone #__________________
SS#____________________________Cell#______________________
Marital Status M D W S Email address________________________
Who told you about our office?______________________________
Who is your family dentist?________________________________
Method of Payment
____Check or cash_____Bank Card______VISA/MASTERCARD
____MEDICAID #________________________________
____Insurance plus co-pay/deductible at time of treatment
Primary Dental Insurance
Insured's Name____________________________Relationship__________
DOB________________________SS#____________________________
EMPLOYER____
GROUP #__________________________Phone #____________________

Financial policy-Fees for dental services are due on the date of treatment. Our office as a courtesy to you, will file for insurance benefits for treatment rendered. At your first visit we request that the balance be paid in full. On subsequent visits, you will be responsible for any deductibles, co-payments, or balances not covered by your insurance. All account balances which have not been paid within 30 days becomes the responsibility of the parent/guardian. There will be a $25.00 charge on all returned checks.

________________________have received a copy of this office's Privacy Practices.
______________________________Patient Name
INDIVIDUAL REFUSED TO SIGN

Child's Medical and Dental History

Name of child's pediatrician or physician_______________________________________

Has your child been hospitalized since birth? Y N If yes, explain_________________

____

Is your child allergic to any medicine or foods? Y N If yes, explain_______________

Is your child presently taking any medication? Y N If yes, please list_____________

____

Has your child ever had any of the following?

NO	YES		NO	YES	
____	____	Asthma	____	____	Ear infections/tubes
____	____	Anemia	____	____	Sinus Trouble
____	____	Allergies	____	____	Thyroid
____	____	Hepatitis	____	____	Cystic Fibrosis
____	____	Abnormal Bleeding	____	____	Latex Allergy
____	____	Diabetes	____	____	Mental/Emotional Disorder
____	____	Handicap/Disabilities	____	____	ADD/ADHD/Hyperactivity
____	____	Tuberculosis	____	____	Blood Disease
____	____	Skin Disorder	____	____	Cancer/Tumor
____	____	Down Syndrome	____	____	Stomach/Kidney Problems
____	____	Rheumatic Fever	____	____	Liver problems
____	____	Heart Condition	____	____	Seizures/Epilepsy
____	____	Pre-Medication Needed	____	____	HIV/AIDS
____	____	Lung Disorder	____	____	Speech
			____	____	Other

Please explain any medical problems that your child has:_____________________________

____

Is this your child's first visit to the dentist? Y N

If not, please give date of last dental care:___________Previous Dentist_______________

Does your child have a dental problem that you are especially concerned?_____________

____

Does your child take fluoride tablets, drops, or vitamins with fluoride? Y N

Is your child on a bottle? Y N If no, what age was it discontinued?__________________

Does your child have a THUMB SUCKING, PACIFIER, OR FINGER HABIT? Y N

Does your child brush his/her teeth daily? Y N If not, how often?___________________

Has your child bumped any teeth? Y N If so, when?_________________________________

Has your child ever had a reaction to dental anesthetic? Y N

Authorization and release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.I authorize the dental staff to perform the necessary dental services my child may need.I also authorize the dentist to release any information, including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I request that my insurance company pay directly to the dentist.I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf.

Signature of Parent/Guardian_____________________________________Date________________