denali pediatric DENTISTRY

(907) 334-9543
2600 Denali Street, Suite 500
Anchorage, AK 99503

Dr. Meghan Foster, D.D.S. | Dr. K.C Rabatin, D.D.S.

Please answer all questions on both sides, so that we may diagnose your child's oral health as accurately as possible.

Responsible Party
(Person who brought to appointment and signed Office Policy)

Relationship to Child

Child's Full Name
Preferred Name ☐ Male ☐ Female
Birthdate Age
Social Security #
Home Phone
Mailing Address
City State Zip

IN CASE OF EMERGENCY, WHO MAY WE CONTACT?

Emergency Contact Name
Relation to Child
Home Phone
Work Phone

Mother's Name		**Father's Name**	
Birthdate Social		Birthdate Social	
Security # Cell		Security # Cell	
Phone Home		Phone Home	
Phone		Phone	
Mailing Address		Mailing Address	
City/State/Zip		City/State/Zip	
Employer		Employer	
Business Phone		Business Phone	
Email Address		Email Address	

With whom does this child reside?

PRIMARY DENTAL INSURANCE

Employee | Relation to Child | Employer
Insurance Co. | ID # | Group # | Insured Birthdate

SECONDARY DENTAL INSURANCE

Employee | Relation to Child | Employer
Insurance Co. | ID # | Group # | Insured Birthdate

I hereby authorize payment directly to Denali Pediatric Dentistry for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Denali Pediatric Dentistry to release the information required to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party **Date**

Whom may we thank for referring you?

DENTAL HISTORY

Is this your child's first dental visit? ☐ Yes ☐ No

Previous Dentist's Name? _____ Last Visit: _____

Does your child feel nervous about having dental treatment? ☐ Yes ☐ No

Has your child ever had a bad dental experience? ☐ Yes ☐ No

Has your child been seen by an orthodontist? ☐ Yes ☐ No

Have there been any injuries to your child's teeth or jaws? Falls, blows, chips, etc.? ☐ Yes ☐ No

Has your child ever been premedicated for dental work? ☐ Yes ☐ No

Does your child receive fluoride in vitamins or tablets? ☐ Yes ☐ No

HEALTH HISTORY

Is your child having any pain or discomfort at this time? ☐ Yes ☐ No

Has your child been hospitalized during the past 2 years? ☐ Yes ☐ No

Has your child been under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

Is your child currently taking any medications? If yes, please list: ☐ Yes ☐ No

Has your child taken any medicine or drugs during the past 2 years? If yes, please list: ☐ Yes ☐ No

Please list any serious medical condition(s) that your child has or has had:

Please check "Yes or No" to the following conditions:

☐	☐	Anemia	☐	☐	Fever Blisters or Cold Sores
☐	☐	Asthma	☐	☐	Heart Murmur
☐	☐	Autism	☐	☐	Hepatitis, Type?
☐	☐	Chemotherapy or Cancer			
☐	☐	Congenital Heart Defect			
☐	☐	Diabetes	☐	☐	HIV or AIDS
☐	☐	Epilepsy	☐	☐	Tonsillitis
☐	☐	Hearing Impaired	☐	☐	Tuberculosis
☐	☐	Other			

MEDICAL HISTORY UPDATE
(FOR OFFICE USE ONLY)

Parent's Signature _____ Date _____

Parent's Signature _____ Date _____

Parent's Signature _____ Date _____

Please check all that apply to your child:

- ☐ Fingernail Biting
- ☐ Lip or Cheek Biting
- ☐ Grinding Teeth
- ☐ Thumb or Finger Sucking
- ☐ Jaw Difficulty: Clicking and/or Pain

Is your child allergic to or reacted adversely to any of the following?

- ☐ Antibiotics
- ☐ Latex
- ☐ Codeine
- ☐ Aspirin
- ☐ Metals or Jewelry
- ☐ Local or Dental Anesthetic

Does your child have allergies to any other medications, foods, or substances? If yes, please list: ☐ Yes ☐ No

Pediatrician/Physician _____

Business Phone _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Meghan Foster, Dr. K.C. Rabatin, and/or dental staff to perform the necessary dental services my child may need.

Parent/Guardian Signature _____ **Date** _____