

denali pediatric DENTISTRY

(907) 334-9543

2600 Denali Street, Suite 500
Anchorage, AK 99503

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

Relationship to Child



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.

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 Home Phone

Relation to Child Work Phone

Mother's Name

Birthdate

Social Security #

Cell Phone

Home Phone

Mailing Address

City/State/Zip

Employer

Business Phone

Email Address

Father's Name

Birthdate

Social Security #

Cell Phone

Home Phone

Mailing Address

City/State/Zip

Employer

Business Phone

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:

Yes	No	Anemia	Yes	No	Fever Blisters or Cold Sores
Yes	No	Asthma	Yes	No	Heart Murmur
Yes	No	Autism	Yes	No	Hepatitis, Type?
Yes	No	Chemotherapy or Cancer	Yes	No	HIV or AIDS
Yes	No	Congenital Heart Defect	Yes	No	Tonsillitis
Yes	No	Diabetes	Yes	No	Tuberculosis
Yes	No	Epilepsy			
Yes	No	Hearing Impaired			
Yes	No	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