Welcome! We at Janesville Pediatric Dental Care are pleased that your children will be joining our dental home as new patients. Dr. Jackie Martin and our staff have dedicated their careers to providing your children with the best that dentistry has to offer.

Informing the parent is a priority at Janesville Pediatric Dental Care. Dr. Jackie's main assistant will meet with you prior to your children's appointments' to discuss any cares, concerns, or questions you may have. You will be asked, at that time, to have a seat in the reception area with the other parents, as your children visit the clinical area. Our staff members will make this transition as easy as possible for both your children and you. If at anytime, our staff feels the necessity for parent assistance, they will inform you.

During a new patient appointment, your children will receive a professional cleaning, necessary radiographs (x-rays), fluoride treatment, and a comprehensive oral examination. Feel confident that your children are receiving the highest quality of dental care.

To help make your initial appointments a success, we ask that you complete the enclosed registration and health history paperwork, prior to your arrival, as well as providing a copy of your insurance card to remain on file for the submission of your dental claims. Please familiarize yourself with the details of your dental insurance plan so we may assist you in estimating your portion of any diagnosed treatment costs. If your children are uninsured, a staff member would be happy to give you an estimate. Payment in full will be required on the day of service. Our office does offer financing options.

If you have any questions or concerns regarding your upcoming appointments, please feel free to contact us at (608)756-3149. We look forward to meeting both you and your children, and welcome to our dental family!

Janesville Pediatric Dental Care

Today's Date: _____

Patient Name: _____ Preferred Name: _____

Birth Date: _____ Age: _____ Gender: _____

RESPONSIBLE PARTY

The parent(s) who bring the child(ren) to their initial visit is the responsible party for the account. In the case of divorce or separation the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child, irregardless of who carries the insurance, is the parent responsible for those subsequent charges, if the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other.

Who is responsible for the account? (if married, both parents are responsible)

Parent/Guardian #1: _____

Marital Status?: Married Single Divorced Seperated

Relation to Patient: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____SS#: _____

E-mail: _____

Parent/Guardian #2: _____

Marital Status?: Married Single Divorced Seperated

Relation to Patient: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____SS#: _____

E-mail: _____

How did you hear about our office? (Circle) Internet Phonebook Friend Flyer Dentist

Please list name of referring Dentist or friend: _____

How do you prefer to be contacted: (Circle) E-mail Home Phone Cell Phone Mail

DENTAL INSURANCE

PRIMARY INSURANCE

Name of Insured: _____

Address: _____

City/State/Zip: _____

Phone: _____

Birth Date: _____SS#: _____

Employer: _____

Occupation: _____

Insurance Company: _____

Address: _____

City/State/Zip: _____

Group #: _____

Insurance ID#: _____

SECONDARY INSURANCE

Name of Insured: _____

Address: _____

City/State/Zip: _____

Phone: _____

Birth Date: _____SS#: _____

Employer: _____

Occupation: _____

Insurance Company: _____

Address: _____

City/State/Zip: _____

Group #: _____

Insurance ID#: _____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf of my dependants.

Signature: _____ Date: _____

Payment for services and estimated insurance co-payments are due at time of service unless other arrangements have been approved in writing. It is also my understanding that 2 (two) consecutive broken appointments without explanation will lead to the dismissal of my family as patients.

Signature: _____ Date: _____

Medical History Form-Janesville Pediatric Dental Care

Patient Name: _____ Today's Date_____

Birth Date: _____

Medical History Does the **Patient** have any history of the following?

Heart Problems or murmur ..... YES NO (?)
Rheumatic fever.....YES NO (?)
Bleeding or clotting problems .....YES NO (?)
Sickle cell anemia or trait .....YES NO (?)
Cleft lip or palate ..... YES NO (?)
Birth defects or genetic disorders.....YES NO (?)
Epilepsy or seizures..... YES NO (?)
Intellectual Disability/Down Syndrome.....YES NO (?)
Autism/Developmental Delay .....YES NO (?)
Growth problems.....YES NO (?)
Cerebral palsy.....YES NO (?)
Ear or hearing problems.....YES NO (?)
Speech difficulties.....YES NO (?)
Vision problems.....YES NO (?)
Asthma or wheezing.....YES NO (?)
Allergies (hay fever, latex sensitivity, etc.) Please List _____ YES NO (?)

_____

Feeding or eating disorders.....YES NO (?)
Hepatitis or liver disease .....YES NO (?)
Diabetes.....YES NO (?)
Tuberculosis.....YES NO (?)
Kidney problems.....YES NO (?)
Bone or joint problems.....YES NO (?)
Drug or alcohol use.....YES NO (?)
Smoking or use of snuff or smokeless tobacco.....YES NO (?)
Sexually transmitted or venereal disease (VD).....YES NO (?)
AIDS or AIDS-related complex.....YES NO (?)
Cancer.....YES NO (?)
Radiation Therapy.....YES NO (?)
Other medical problems (specify) _____YES NO (?)

Name of patient's physician _____ Date of last visit _____
Address _____ Phone # _____
Is the patient currently under the care of a physician?.....YES NO (?)
If yes, for what condition? _____
Has your medical doctor instructed you to have your child take Penicillin before each dental visit.....YES NO (?)
Is the patient currently taking any medications?.....YES NO (?)
If yes, list _____
for what condition? _____
Has the patient had any allergic or unfavorable reaction any medications?.....YES NO (?)
To what? _____ Reaction _____
Have you or your child had any complications due to anesthesia?.....YES NO (?)
Has the patient ever been hospitalized?.....YES NO (?)
Age _____ Reason
_____
Are the patient's immunizations up-to-date?..... YES NO (?)
Is there any additional medical information about the patient not reported above?.....YES NO (?)
If yes, describe _____

DENTAL HISTORY

Why is the patient seeking dental care? _____

Is this the patient's first visit to a dentist?.....YES NO (?)

If no, please provide name of dentist and date of last visit _____

_____

Has the patient had any of the following dental problems?

Injuries to mouth or teeth……..YES NO (?)

Toothaches/pain……..YES NO (?)

Abscesses (gum boils)……..YES NO (?)

Other (specify) _____

Does the patient have any of the following habits?

Finger/thumb/pacifier sucking ……..YES NO (?)

Tooth grinding or clenching……..YES NO (?)

Other (specify) _____

At what age was bottle or breast feeding stopped? _____

What is the source of the patient's current drinking water supply?

_____ City _____ Home well _____ Bottled _____ Don't know

Is this water fluoridated?.....YES NO (?)

Does patient receive fluoride tablets, drops or vitamins with fluoride?.....YES NO (?)

Who is responsible for brushing the patient's teeth? _____

Is there any additional dental information we should know?_____

_____

SOCIAL & BEHAVIORAL HISTORY

Do you think the patient will cooperate for dental treatment?.....YES NO (?)

Has the patient had a bad or fearful dental or medical experience?.....YES NO (?)

Which of the following best describes the patient?

_____ Advanced in the learning process _____ Progressing normally _____ Slow learner

Does the patient have any history of emotional or behavioral problems?.....YES NO (?)

If yes, describe _____

Are there any cultural, religious or ethnic concerns that could affect the care of your child?.....YES NO (?)

If yes, describe _____

Names and ages of other children in the family _____

_____

Is there any additional information we should know?.....YES NO (?)

If yes, comment _____

_____

In case of hospitalization, trauma or emergency, please provide the name of your medical Insurance provider/company _____

To the best of my knowledge the above information is correct.

_____	_____	_____
Signature of person completing/Reviewing form	Date	Relationship to patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____