Dr. Frank Edge
Pediatric Dentistry
1311 Kimber Lane
Evansville, IN 47715
(812) 477-3393

brush your teeth everyday

DENTAL HISTORY

Have you seen a dentist before? If Yes, place and date of last exam, cleaning, and xrays. ☐Yes ☐No _____

Any prior dental treatment? If Yes, How did you do? ☐Yes ☐No _____

Any unhappy dental experiences? If Yes, Please explain. ☐Yes ☐No _____

DAILY ROUTINE

Do you brush daily? ☐Yes ☐No Do you have help brushing? ☐Yes ☐No Do you floss? ☐Yes ☐No

Do you use fluoride rinse? ☐Yes ☐No Do you use fluoridated toothpaste? ☐Yes ☐No

HABITS

Pacifier ☐Yes ☐No Sippy/Bottle to Bed ☐Yes ☐No Thumb/Finger Sucker ☐Yes ☐No

Frequent Snacker ☐Yes ☐No Juice Drinker ☐Yes ☐No Soda Drinker ☐Yes ☐No

Sports Drinks ☐Yes ☐No Bottle ☐Yes ☐No

MEDICAL HISTORY

Are you under a physician's care? ☐Yes ☐No _____

Have you ever been hospitalized or had any surgeries? ☐Yes ☐No _____

If Yes, please explain. _____

Are you taking any medications? Please list. ☐Yes ☐No _____

Were you premature? (37 weeks or less) If Yes, how ☐Yes ☐No _____

premature and how long in NICU? _____

ALLERGIES

☐Asprin ☐Codeine ☐**DEMEROL** ☐Keflex

☐Latex ☐Local Anesthetic ☐Omnicef ☐Penicillin/Amoxicillin

☐Red Dye ☐Seasonal Allergies ☐Sulfa ☐Tree Nuts

☐Other, Please list _____

ARE YOU, OR HAVE YOU BEEN DIAGNOSED BY A PHYSICIAN WITH ANY OF THE FOLLOWING?

ACID REFLUX/GERD ☐Yes ☐No	CHEMOTHERAPY ☐Yes ☐No	LIVER DISEASE ☐Yes ☐No	THYROID DISEASE ☐Yes ☐No
ADHD/ADD ☐Yes ☐No	DEPRESSION ☐Yes ☐No	LUNG DISEASE ☐Yes ☐No	ULCERS ☐Yes ☐No
AIDS/HIV POSITIVE ☐Yes ☐No	DIABETES ☐Yes ☐No	MENTAL DELAY ☐Yes ☐No	VISUALLY IMPAIRED ☐Yes ☐No
ANEMIA ☐Yes ☐No	EPILEPSY/SEIZURES ☐Yes ☐No	PSYCHIATRIC CARE ☐Yes ☐No	
ANXIETY ☐Yes ☐No	HEARING LOSS ☐Yes ☐No	SENSORY ISSUES ☐Yes ☐No	
ASTHMA ☐Yes ☐No	HEART MURMUR ☐Yes ☐No	SICKLE CELL ☐Yes ☐No	
AUTISM/ASPERGERS ☐Yes ☐No	HEPATITIS A ☐Yes ☐No	SLEEP APNEA ☐Yes ☐No	
BEHAVIOR ISSUES ☐Yes ☐No	HEPATITIS B OR C ☐Yes ☐No	SPINA BIFIDA ☐Yes ☐No	
CANCER ☐Yes ☐No	KIDNEY PROBLEMS ☐Yes ☐No	STOMACH/INTESTINAL ☐Yes ☐No	
CEREBRAL PALSY ☐Yes ☐No	LEUKEMIA ☐Yes ☐No	STROKE ☐Yes ☐No	

Do you have any heart condition? If Yes, please list ☐Yes ☐No _____

condition and cardiologist name and number. _____

Have you been diagnosed or seeing a physician for ☐Yes ☐No _____

anything not listed above? _____

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PATIENT INFORMATION

Date_____ SS/HIC/Patient ID#_____ Birthdate_____

Name of Minor/Child _____ Sex ☐M ☐F Age_____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (___)_____

Home Address_____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name_____ School Phone (___) _____

Person financially responsible _____ Home Phone (___)_____ Work Phone (___) _____

How did you hear about our office?_____

INSURANCE

Father's /Guardian's Name _____

Address *(if different from patient's)* _____

Home Phone (___)_____ Work Phone (___)_____
(if different from above) *(if different from above)*

Email _____

Employer _____

Soc. Sec.# _____ Birthdate_____

Do you have dental insurance coverage for minor/child? ☐Yes ☐No

Plan Name_____ Phone (___)_____

Address _____

Group # _____ Policy # (___)_____

Is your child eligible for treatment under Medical Assistance? ☐Yes ☐No

Mother's/ Guardian's Name _____

Address *(if different from patient's)* _____

Home Phone (___)_____ Work Phone (___)_____
(if different from above) *(if different from above)*

Email _____

Employer _____

Soc. Sec.# _____ Birthdate_____

Do you have dental insurance coverage for minor/child? ☐Yes ☐No

Plan Name_____ Phone (___)_____

Address _____

Group # _____ Policy # (___)_____

Child's Medical Assistance I.D.#_____

EMERGENCY CONTACT

In the event of an emergency, who should we contact?

Name_____ Relationship _____ Phone (___) _____

Name_____ Relationship _____ Phone (___) _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent: I am the parent, guardian or personal representative of _____ *(Please print name of Minor/Child)* and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release: I certify that my depended(s) is covered by insurance with _____ *(Name of Insurance Company(ies))* and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Parent, Guardian or Personal Representative *Date*

_____ _____
Please print name of Parent, Guardian or Personal Representative *Relationship to Patient*