WELCOME
John P. Waschak, D.D.S, MS
Grants Pass Pediatric Dentistry & Orthodontics

ABOUT YOUR CHILD

_____
Child's Name

_____ □M or □F _____
Age Date of Birth

REASON FOR THIS VISIT
_____
_____
_____

REFERRED TO THIS OFFICE BY (We wish to thank them):

_____
Full Name Phone number

DENTAL HISTORY

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

_____
Previous Dentist City

_____
Date of last visit

Were dental x-rays taken? □ yes □no
If yes when?_____

Any injuries to your child's teeth or jaws?_____
When? _____

History of:	When?
□ Breast feeding	_____
□ Bottle habits	_____
□ Thumb/finger sucking	_____
□ Pacifier	_____
□ Dental grinding/clenching	_____

Has your child experienced any unfavorable reaction from previous medical or dental care?
□ yes □ no (If yes, please explain)
_____
_____

Has your child had recent dental pain?
_____

MEDICAL HISTORY

* Is your child presently under the care of your family physician for any medical reason? □ Yes □No
If yes, what? _____
_____
Date of last physical exam
_____
Family physician's name Phone number

*Is your child presently under the care of a specialist for any medical reason? If yes, explain._____
*Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt, or other medical reason?
*Is your child presently taking medications?
If so, what? _____
*Has your child ever been hospitalized or had surgery?
For what? _____
*Does your child have any allergies to medications, food, latex, other? If so what? _____
*Has any member of the family, including your child, had a problem with general anesthesia? □ Yes □No

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK YES OR NO:

Y N		Y N	
□□	Aids-HIV	□□	Excessive gagging
□□	Anemia	□□	Fainting or dizziness
□□	Arthritis	□□	Fever blisters
□□	Asthma	□□	Growth/developmental problem
□□	Autism	□□	Heart surgery
□□	Bladder conditions	□□	Headaches
□□	Blood disease	□□	Hearing/Speech Impairments
□□	Blood transfusions	□□	Heart Murmur/Defect
□□	Birth defects	□□	Hemophilia
□□	Bone or joint problems	□□	Hepatitis/Liver Disease
□□	Brain injury	□□	High Blood Pressure
□□	Bruising easily	□□	Kidney Disease
□□	Cancer	□□	Leukemia
□□	Cerebral palsy	□□	Mental Disability
□□	Chemotherapy/radiation	□□	Mouth Sores
□□	Child abuse	□□	Nutritional Deficiency
□□	Chronic ear infections	□□	Orthopedic Problems
□□	Cleft lip/palate	□□	Pain in Jaw Joints
□□	Congenital heart lesion	□□	Premature Birth
□□	Convulsions/seizures	□□	Psychiatric Care
□□	Diabetes	□□	Rheumatic Fever
□□	Drug addiction	□□	Scoliosis
□□	Emotional disturbance	□□	Sickle Cell Anemia
□□	Epilepsy	□□	Syndrome_____
□□	Eye problems	□□	Tonsil infection
		□□	Tuberculosis
		□□	Other_____

PREVENTATIVE DENTAL CARE

How often does your child brush? _____
Is tooth brushing supervised? Yes □ No □
By whom? _____
Do you help your child brush? Yes □ No □
Is dental floss used? Yes □ No □
Does your child receive?
Fluoride in vitamins □ Bottled water □
Fluoride tablets/drops □ Well water □
Fluoridated water □

RESPONSIBILITY

Father or Guardian's Name

Address

City State Zip

SS# Birth Date

Home phone Work phone

Employer Occupation

Email address Cell phone

Mother or Guardian's Name

Address

City State Zip

SS# Birth Date

Home phone Work phone

Employer Occupation

Email address Cell phone

DENTAL INSURANCE

Primary Insurance Group#

Policy Holder Name ID#

Secondary Insurance Group#

Policy Holder Name ID#

NEAREST RELATIVE/FRIEND

Name

Address

Phone # Relationship

AUTHORIZATION

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. If my account goes 90 days past due my balance will accrue finance charges at 19% APR or a minimum charge of $2.50, whichever is greater, which I will be held responsible. If my account requires servicing by a collection agency or by an attorney I understand that I will be liable for the collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request payment under my dental insurance program be made directly to Dr. John P. Waschak DDS, MS on any unpaid bills for services furnished to me or my family. I authorize the release of any dental information necessary to process this claim and all future claims.

Signature Date

The permission of parent or guardian is necessary for dental treatment of a minor:

I give the doctors permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (X-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollen, dust, or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my child's health or any other physical conditions, that my child's medical doctor has advised me should be reported to a dentist.

Signature Relationship to Child Date

Reviewed By