

WELCOME



John P. Waschak DDS, MS, PC
1501 NE 6th Street. Grants Pass, OR 97526
Phone: 541-476-8383 Fax: 541-479-0751

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