Burleson
pediatric dentistry

101 NW Renfro Street #106
Burleson, TX 76028

817-447-7474
www.burlesonkids.com

Dr. Chris Walton, DDS

Date:_____

Patient Information

Patient Name:_____ Age:_____

Preferred Name: _____ DOB:_____ Gender: ☐ M ☐ F

Weight:_____ School Attending:_____ Grade:_____

Street Address:_____

City: _____ State: _____ Zip Code:_____ SS#:_____

Name(s) and age(s) of siblings:_____

Favorite pet, playmate, toy, hobby, or sport:_____

Who is accompany child today?_____ Relationship:_____

I consent to Burleson Pediatric using my child's name/photo on social media ☐ Y ☐ N

Primary Phone# for Appointment Confirmation:_____

With whom, does the patient live?_____

How did you hear about us?

☐ Patient:_____ ☐ Dental Office:_____

☐ Google ☐ Facebook ☐ Magazine ☐ Other_____

Parent Information

Mother's Information:

☐ Mother ☐ Step ☐ Legal Guardian

Name:_____

DOB:_____ SS#:_____

Marital Status:
☐ Single ☐ Married ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed

Home#:_____

Cell#:_____

Work#:_____

Email: _____

Father's Information:

☐ Father ☐ Step ☐ Legal Guardian

Name:_____

DOB:_____ SS#:_____

Marital Status:
☐ Single ☐ Married ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed

Home#:_____

Cell#:_____

Work#:_____

Email:_____

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☐ Check if Address is same as patient's listed above.

Street Address:_____

City:_____

State:_____ Zip Code:_____

Employer:_____

Position:_____

Mother's Dentist:_____

☐ Check if Address is same as patient's listed above.

Street Address:_____

City:_____

State:_____ Zip Code:_____

Employer:_____

Position:_____

Father's Dentist:_____

Who else has permission to bring child to their appointment?

Name:_____

Relationship to patient:_____

Marital Status:

☐ Single ☐ Married ☐ Domestic Partnership

☐ Separated ☐ Divorced ☐ Widowed

☐ Check if Address is same as patient's listed above.

Street Address:_____

DOB:_____

SS#:_____

Home#:_____

Cell#:_____

Work#:_____

Email:_____

City/State/Zip:_____

Dental Insurance Information

***Primary Coverage*:**

Policy Holder's Name:_____

DOB:_____ SS#:_____

Employer:_____

Insurance Company:_____

Phone:_____

Street Address:_____

City/State/Zip:_____

Policy/Member ID#:_____

Group #:_____

***Secondary Coverage*:**

Policy Holder's Name:_____

DOB:_____ SS#:_____

Employer:_____

Insurance Company:_____

Phone:_____

Street Address:_____

City/State/Zip:_____

Policy/Member ID #:_____

Group #:_____

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Medical History

Has your child been diagnosed and/or treated for any of the following:

- ☐ Blood Disorder/Anemia
- ☐ Abnormal Bleeding/Hemophilia
- ☐ Immune Disorder/HIV/AIDS
- ☐ Cancer/Tumor/Leukemia
- ☐ Heart Murmur/Defect/Surgery
- ☐ Epilepsy/Seizures/Convulsions
- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ Kidney Problems
- ☐ Liver Disease/Jaundice/Hepatitis
- ☐ Diabetes
- ☐ Sickle Cell Trait
- ☐ Stomach/GI Disorders
- ☐ Tuberculosis (TB)
- ☐ Asthma/Reactive Airway
- ☐ Tonsillitis
- ☐ Congenital Birth Defects
- ☐ Premature/Low Birth Weight
- ☐ Cleft Lip/Palate
- ☐ Autism Spectrum
- ☐ ADD/ADHD
- ☐ Eating Disorder
- ☐ Speech Disorder
- ☐ Vision Problems
- ☐ Hearing Problems/Deaf
- ☐ Mental/Cognitive/Social Delay

Allergies

- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Codeine
- ☐ Latex
- ☐ Other

Child's Physician:_____ Phone:_____

Was your child full term? ☐ Yes ☐ No If not, how may weeks at delivery?_____

Date of Last Exam:_____ Are immunizations current? ☐ Yes ☐ No

History of Hospitalizations:_____

Is your child taking any medication(s) now? ☐ Yes ☐ No

If so, please list:_____

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Dental and Diet History

Does your child currently have a toothache? ☐ Yes ☐ No

If yes, how frequent? _____

Is this your child's first visit to a dentist? ☐ Yes ☐ No

If not, please share with us why you wish to make a change?_____

_____ Date Last X-Rays:_____

How would you describe your child's previous medical or dental experiences?

_____

How would you rate your own anxiety at this moment? ☐ High ☐ Medium ☐ Low

How would you expect your child to react in the dental chair? ☐ Good ☐Medium ☐ Poor

Does your child have a history of any of the following?

1. Cavities/decayed teeth: ☐Yes ☐No
2. Clinching/grinding teeth: ☐Yes ☐No
3. Excessive gagging: ☐Yes ☐No
4. Family history of cavities or dental characteristics? ☐Yes ☐No
   If so, please explain:_____
5. Does your child have any oral habits?
   ☐ Pacifier ☐ Sucks Thumb ☐ Sucks fingers ☐ Grinds teeth ☐ Other
   If so, how often do they do it?_____
6. Has your child ever had any trauma to a tooth? ☐Yes ☐No
   If so, when and how?_____
7. Has your child ever had previous orthodontic treatment (braces, spacers, or other appliances)?
   ☐Yes ☐No If so, where?_____

Brushing and Flossing

1. Does your child brush in the morning and night? ☐Yes ☐No
2. Does your child brush with fluoridated toothpaste? ☐Yes ☐No
3. Does an adult help? ☐Yes ☐No If so, when?_____
4. Are your child's teeth flossed? ☐Yes ☐No
   If so, how often?_____ By Whom?_____
5. Does your child usually drink anything other than water BEFORE bed, AFTER brushing?
   ☐Yes ☐No

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Dietary Habits

1. Is your child on a special or restricted diet? ☐Yes ☐No
2. What does your child snack on during the day?_____
3. How many times does he/she snack during the day? ☐ 1-3 times ☐ > 3 times/day
4. What does your child generally drink during meals? ☐ Water ☐ Juice ☐ Milk ☐ Other
5. What does your child generally sip on during the day? ☐ Water ☐ Juice ☐ Milk ☐ Other

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand that Burleson Pediatric Dentistry may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Burleson Pediatric Dentistry all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.

Guardian Signature: _____ **Date:** _____