Julie M. Longoria DDS MSD & Associates
Diplomates American Board of Pediatric Dentistry

**Patient Info:**

Child's Name: ______________________________ Child's Birthdate: ______/______/______ Child's Age: __________
Last First MI

Nickname: ______________________ ☐ Male ☐ Female Is your child adopted? ☐ Yes ☐ No

**Medical History:**

Child's Physician: ____________________ Phone: (_____)____________ Date of last visit: ________________

Address: ______________________________________________________________
Street City State Zip

Is your child currently under the care of a specialist? ☐ Yes ☐ No Please explain: ____________________

Was your child born premature? ☐ Yes ☐ No Weeks gestation? ______________ Birth weight: ________________

Feeding tube used? ☐ Yes ☐ No How long? __________________________

Breathing tube used? ☐ Yes ☐ No How long? __________________________

Does your child have a social/personality/temperament disorder? ☐ No ☐ Yes Please explain:

______________________________________________________________

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor Last immunizations: ________________

Please list all medications and dosage that your child is currently taking: ________________________

Please list all drugs and/or foods that cause your child allergic reactions: ________________________

Anything you would like to discuss with the doctor in private? ☐ Yes ☐ No ______________________

Does your child have asthma? ☐ Yes ☐ No Has your child been hospitalized for asthma? ☐ Yes ☐ No

Last asthma attack? ________ What causes an attack? ______________ Medications: ________________

Does your child have diabetes? ☐ Yes ☐ No ☐ Type 1 ☐ Type 2 Medicatons: ____________________

Has your child been hospitalized for any reason or had any previous surgeries? ____________________

______________________________________________________________

Has your child had/experienced any of the following: (please circle any conditions applicable)

| | | | |
|---|---|---|---|
| AIDS/HIV+ | Congenital Birth Defect | Hemophilia | Reactive Airway |
| Allergies | Congenital Heart Defect | Hepatitis | RSV |
| Anemia | Cystic Fibrosis | High Blood Pressure | Seizures |
| Asthma | Diabetes | Hospitalizations | Sickle Cell Anemia |
| Autism | Down Syndrome | Kidney Disease | Speech/Visual Impairment |
| Breathing/Lung Problems | Eczema | Liver/GI Systems Problems | Surgeries |
| Cancer/Tumors | Endocrine System Disorders | Lupus | Thyroid Disorder |
| Cerebral Palsy | Epilepsy | Mitral Valve Prolapse | Tonsils/Adenoids |
| Chronic Sinusitis | Frequent Infections | Mononucleosis | Tuberculosis (TB) |
| Cleft Lip/Palate | Heart Murmur | Other: ______________ | |

## Dental History:

Is your child currently having any dental pain? ☐ No ☐ Yes, explain:____________________

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

Has your child experienced problems with previous dental work? ☐ Yes ☐ No If so, explain:________________

Previous Dentist: ________________ Date of Last Visit: __________ Date of last x-rays: ____________

Have there been any injuries to your child's teeth, jaws, falls, blows, chips, etc? ☐ Yes ☐ No

What type of water does your child drink most often? ☐ Tap water/Faucet ☐ Refrigerator/Filtered ☐ Bottled ☐ Reverse Osmosis (hard water remover) ☐ Nursery Water ☐ Well Water

Does / did your child have any of the following habits? (please circle)

| | | |
|---|---|---|
| Bottle | Pacifier Excess | TMJ |
| Bruxism/Grinding | Snoring | Tongue Thrust |
| Nail Biting | Snoring | |
| Nursing | Thumb/Finger Sucking | |

How would you predict your child's behavior to be? Cooperative Defiant Fearful Don't know

## Parents Information:

Family's Home Address: ________________________________
Street City State Zip Code

E-Mail:____________________ Parent's Marital Status: ☐ Married ☐Divorced ☐ Single

Parent or Guardian Full Name: ____________________ Cell Phone #: ( )________________

Address (If different from above): ________________________________

SS#: ______-____-______ DOB: ________________

Employer: ________________________ Occupation: ____________________

Parent or Guardian Full Name: ____________________ Cell Phone #: ( )________________

Address (If different from above): ________________________________

SS#: ______-____-______ DOB: ________________

Employer: ________________________ Occupation: ____________________

Insurance Information:

Dental Insurance Carrier: ____________________ Group No: ____________________

**We are happy to accept your insurance benefits for payment. We will estimate your portion to the best of our abilities. We require that you pay the estimated amount on the day the services are rendered. Any other remainders, after the insurance has paid their part, are due no later than 30 days after the insurance payment has been received. Any claims not paid within 60 days will be <u>YOUR RESPONSIBILITY</u>. Should the patient be paid in error by your insurance company, contact Dr. Julie Longoria for further instruction immediately.**

**I hereby authorize payment directly to Dr. Julie Longoria & Associates of the Group Ins. Benefits otherwise payable to me.**

☆________________________ ________________

Signature Date

**It is necessary that a signed permission is obtained from a parent or guardian before any or all necessary dental services can be started and accomplished. The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental service and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, I will be responsible for any bill incurred on this child for dental treatment. <u>We would appreciate acknowledgement of your receipt of our policy by signing below.</u>**

☆________________________ ________________

Signature Date