Melissa Mullane Padgett, DDS
General Dentist Accepting Children

We are pleased to welcome you and your child to our practice! Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Patient Information

Patient Name ______________________ Preferred Name ______________

DOB ______________ Sex ☐ M ☐ F Home Phone ______________________

Address ____

Guardian Information

Mother's/Guardian's Name ______________________

Social Security # ______________ DOB __________

Address (if different than above) ______________________

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Phone (Home) ______________ (Cell) ______________

(Work) ______________________

Email Address ______________________

Father's/Guardian's Name ______________________

Social Security # ______________ DOB __________

Address (if different than above) ______________________

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Phone (Home) ______________ (Cell) ______________

(Work) ______________________

Email Address ______________________

Dental Insurance Information

Primary: Plan name ____

Subscriber's name ______________________ Employer ______________

Group # ______________ Policy # ______________ Card Copy ☐ Yes ☐ No

Secondary: Plan name ____

Subscriber's name ______________________ Employer ______________

Group # ______________ Policy # ______________ Card Copy ☐ Yes ☐ No

Does the child have dental coverage through the State of Ohio? Medicaid ☐ Yes ☐ No

Caresource ☐ Yes ☐ No United Health Care Community Plan ☐ Yes ☐ No BCMH ☐ Yes ☐ No

If yes, we must have a copy of the card at **EACH VISIT**.

Primary or Secondary coverage (circle one) ID # ______________________________

Signature ______________________ Date __________ Relationship to patient ______________

Last Revised June 2013

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Medical History

Child's Name ______________________________ DOB ______________

Pediatrician/Medical Physician Name/Phone______________________________

Specialist (cardiologist, endocrinologist, counselor, etc,) Name/Phone ______________________________

Do you have or have you had any of the following? (Check all that apply)

- ☐ ADD/ADHD
- ☐ Anxiety General
- ☐ Anxiety Dental
- ☐ Asthma
- ☐ Autism/Asperger's
- ☐ Bipolar
- ☐ Bleeding Disorder
- ☐ Cancer/Leukemia
- ☐ Cerebral Palsy
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Epilepsy/Seizures
- ☐ Frequent Ear Infections
- ☐ Frequent Fainting
- ☐ Hearing Difficulties/Deaf
- ☐ Heart Problems
- ☐ Atrial Septal Defect
- ☐ Ventral Septal Defect
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ HIV/AIDS
- ☐ Kidney Problems
- ☐ Learning Disabilities
- ☐ Liver Problems
- ☐ Mental Health Problems
- ☐ Non-verbal (ages 3+)
- ☐ Rheumatoid Arthritis
- ☐ Tonsillitis
- ☐ Other ______________

Surgery? Describe______________________________

Admitted to hospital or over night stay? Describe______________________________

Medications, vitamins, supplements? Name/s ______________________________

For what ?______________________________

Allergies: (Check all that apply)

- ☐ Amoxicillin/Penicillin
- ☐ Codeine
- ☐ Latex
- ☐ Food ______________
- ☐ Seasonal ______________
- ☐ Other Medications ______________

Dental History

Bad experience? Y/N Explain______________________

Brush teeth ______________________ times per day/week

Floss teeth ______________________times per day/week

Injuries to mouth, teeth, head______________________

Children under age 5:

Pacifier Y/N Age stopped________

Bottle Y/N Age stopped________

Sippy cup Y/N Age stopped________

Thumb sucking Y/N Age stopped________

Sleeping with bottle/sippy cup Y/N Age stopped________

Other info?______________________

Authorization

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

Minor/Child Consent

I am the parent, guardian or personal representative of ______________________(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 team to perform necessary services for the child named above, including but not limited to radiographs, administration of anesthetics, and administration of nitrous oxide, which are deemed advisable by Dr. Padgett, whether or not I am present when the treatment is rendered.

Signature______________________________ Date_________ Relationship to patient ______________