KATIE STEELE, DDS, PLLC
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Welcome to our practice! We look forward to caring for your children's dental health! Please complete the following form to help us best serve you.

Patient Information

1. ***Tell us about your child.***

Full name: ______________________________ Preferred name: ________________ Male: __ Female: __
Age:___ Date of Birth: _______ Names and ages of siblings:____
Email address:____

Father's Full name:______________________Phone: _________________Mobile:________________________
Home address:____
City:___________________________________State:____________Zip:_________________________________
Date of Birth:_____________ Occupation:____

Mother's Full name:_____________________Phone: __________________Mobile:_______________________
Home address:____
City:___________________________________State:____________Zip:_________________________________
Date of Birth: ______________Occupation:____

Preferred Contact Person/Method: ________________________at____________________________________
Parents marital status:_______________
Emergency Contact (other than parents):______________________________Phone: ______________________

2. ***Electronic Communications.***

The confidentiality of electronic communications (e-mail, text, etc.) cannot be guaranteed and Steele Pediatric Dentistry is not responsible for the confidentiality or security of any message sent. If any contact information changes, please notify Steele Pediatric Dentistry.

______I authorize Steele Pediatric Dentistry to contact me via electronic media.
______I do NOT authorize Steele Pediatric Dentistry to contact me via electronic media.

3. ***Dental Insurance.***

Primary Dental Insurance Co. and Address: ____
Insured name:________________________________Relationship to patient:_____________________________
Date of Birth:__________________________Social security Number:___________________________________
Employer:__________________________________Group #____

Secondary Dental Insurance Co. and Address: ____
Insured name:________________________________Relationship to patient:____________________________
Date of Birth:__________________________Social security Number:___________________________________
Employer:__________________________________Group #____

4. Dental/Medical History.

Who is dentist for your family? ____

When & where was your child's last dental cleaning? ____

When & where was your child's most recent dental x-rays? _______________________________________

Who is the child's pediatrician? ______________________________ at ____________________ (Phone #)

Please indicate if your child has any of the following medical concerns.

General Conditions
__Arthritis
__Asthma
__Diabetes
__Gastrointestinal Disorder
__Heart Disease
__Heart Murmur
__Kidney Disease
__Rheumatic Fever

Behavior/Learning
__ADD/ADHD
__Anxiousness/Nervousness
__Autism
__Behavioral Issues
__Learning Disabilities
__Psychiatric Disorder

Developmental
__Brain Injury
__Cerebral Palsy
__Cleft Lip/Palate
__Developmental Delay
__Feeding/Eating Problems
__Growth Problems
__Hearing Loss
__Neuromuscular Defect
__Seizures
__Speech Delay
__Spina Bifida

Hematological
__Anemia
__Hemophilia
__Sickle Cell Disease
__Von Willebrand's Disease

Infectious
__Hepatitis
__HIV infection
__AIDS
__Tuberculosis

Other
__Adenoids
__Cancer
__Leukemia
__Fainting
__Headaches
__Sleep Apnea
__Latex Allery
__Other (please describe)

Is your child in good health? Yes No
Are your child's immunizations current? Yes No
Does your child have any allergies? Yes No
If yes, please explain: ____________________
Does your child have regular check-ups? Yes No
Has your child ever had surgery? Yes No
If yes, please explain: ____________________
Has your child ever been admitted in the hospital? Yes No
If yes, please explain: ____________________
Has your child ever been instructed to take antibiotics before dental treatment? Yes No
If yes, please explain: ____________________
Was your child premature, low birth weight or intubated as a newborn? Yes No
How often does he/she brush his/her teeth? ___________
How often does he/she floss his/her teeth? ___________
Will your child be a cooperative patient? Yes No

Does your water contain Fluoride? Yes No
Have there been any injuries to your child's teeth/mouth? Yes No
If yes, please explain: ____________________
Does or did you child have an oral habit (thumb, pacifier, etc.)? Yes No
If yes, please explain: ____________________
If bottle fed, at what age did your child stop? ________

What does your child eat/drink on a daily basis?
____
____

What medications (if any) does your child take?
____
____

Do you have any specific concerns about your child's oral health to be discussed with Dr. Steele?
____
____

As the legal guardian of this child, I grant the staff permission to treat the dental needs of my child including dental emergencies. I authorize the release of information required to process insurance claims. I further agree to pay the fees incurred even if not covered by insurance. This includes legal and collection fees if my account is not paid within 90 days. I also agree to binding arbitration should a dispute arise.

I understand the above information and all of my questions have been answered. I guarantee the above information is correct and understand that is it my responsibility to inform this office of any changes.

Signature: ____ Date: _________________________