

Crane Pediatric Dentistry  
Dr. Megan Crane, DDS  
**Welcome to our Practice!**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ Gender:  Male  Female  
Primary Number: \_\_\_\_\_ (C/W/H) Secondary Number: \_\_\_\_\_ (C/W/H)  
Address: \_\_\_\_\_  
Street Apartment Number  
City State Zip

Best Email address to confirm appointments: \_\_\_\_\_  
Does your child have any siblings we already treat?  Yes  No \_\_\_\_\_  
Where does your child go to school or day care? \_\_\_\_\_

**Referral Information:**

How did you find out about our office?  Referred by another physician or dentist  Referred by a friend  Phonebook  
 Another child in your family  Other \_\_\_\_\_

Who can we thank for referring you to our office? \_\_\_\_\_

**Patient Dental History:**

What is the reason for your child's dental visit today? \_\_\_\_\_

Is this your child's first visit to the dentist?  Yes  No. If no, when was the last visit? \_\_\_\_\_

Previous Dentist's Name: \_\_\_\_\_

Did they take x-rays at their last visit?  Yes  No

Have there been any injuries to the teeth, face, or mouth? If yes, please explain \_\_\_\_\_

Does your child have any major dental problems?  Yes  No

Is your child's water fluoridated?  Yes  No Does a parent assist with brushing/flossing your child's teeth?  Yes  No

Does your child floss his/her teeth daily?  Yes  No Does your child brush his/her teeth daily?  Yes  No

Do you think your child will react well to dental treatment?  Yes  No

Explain \_\_\_\_\_

Has your child ever had a serious or difficult problem associated with previous dental work? \_\_\_\_\_

Does your child have any of the following habits? *Please circle all that apply.*

**Lip Sucking/Biting      Pacifier Habit      Nail Biting      Thumb/Finger Habits      Teeth Grinding      Nursing/Bottle Habits.**

**Patient Health History:**

Name of Child's Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Yes  No Is your child currently under the care of a Physician?

If so, why? \_\_\_\_\_

Yes  No Has your child ever been hospitalized? Emergency Room? \_\_\_\_\_

Yes  No Has your child had any surgeries or operations? \_\_\_\_\_

Yes  No Is your child taking any medications? (Please give the name of medications, dose, and reason):

\_\_\_\_\_

**Asthma Related Questions**

*If your child has asthma, please read the following questions carefully and answer them with as much information as you can provide. Asthma can affect dental treatment for children in many ways and we need as much detail as possible.*

Does your child have asthma?  Yes  No. When was asthma diagnosed? \_\_\_\_\_

When was the last asthma attack? \_\_\_\_\_ Do you consider asthma controlled?  Yes  No

When was the last medical evaluation for asthma? \_\_\_\_\_ Does your child carry an inhaler?  Yes  No

Has your child ever been hospitalized due to asthma?  Yes  No. What causes the asthma attacks? \_\_\_\_\_

Does your child take any medications for asthma?  Yes  No. Please list: \_\_\_\_\_

Has your child had an attack occur in a dental office?  Yes  No. How often do you replace the inhaler? \_\_\_\_\_

**Has your child ever been diagnosed with any of the following:**

*Please check all that apply and explain any issues on the lines below.*

No known health concerns  Yes  No

ADHD/ADD/Hyperactivity  Yes  No

Acid Reflux/GERD  Yes  No

Allergies  Yes  No

Latex  Yes  No

Food  Yes  No \_\_\_\_\_

Medication  Yes  No \_\_\_\_\_

Other  Yes  No \_\_\_\_\_

Anemia  Yes  No

Anxiety  Yes  No

Arthritis  Yes  No

Artificial Joints/Stent  Yes  No

Asthma  Yes  No

Autism/Asperger's  Yes  No

Birth Defects  Yes  No

Blood Disease  Yes  No

Blood Transfusion  Yes  No

Cancer  Yes  No

Treating Physician: \_\_\_\_\_

Celiac Disease  Yes  No

Cerebral Palsy  Yes  No

Cleft Lip/Palate  Yes  No

Cystic Fibrosis  Yes  No

Depression  Yes  No

Developmental Delay  Yes  No

Diabetes  Yes  No

Epilepsy/Seizures  Yes  No

Eczema  Yes  No

Glaucoma  Yes  No

Head Injuries  Yes  No

Hearing Issue  Yes  No

Heart Disease  Yes  No

Heart Murmur  Yes  No

Innocent  Yes  No

Requires Pre-Med  Yes  No

Treating Specialist: \_\_\_\_\_

Hepatitis  Yes  No

High Blood Pressure  Yes  No

HIV/AIDS  Yes  No

Hydrocephalus  Yes  No

Immunodeficiency  Yes  No

Kidney Disease  Yes  No

Learning Disabled  Yes  No

Mental Disorder  Yes  No

MRSA  Yes  No

Pacemaker  Yes  No

Physically Challenged  Yes  No

Pregnancy  Yes  No

Due Date: \_\_\_\_\_

Radiation Treatments  Yes  No

Respiratory Problems  Yes  No

Rheumatic Fever  Yes  No

Scarlet Fever  Yes  No

Sensory Disorder  Yes  No

Sinus Problems  Yes  No

Speech Disorder  Yes  No

Stomach Problems  Yes  No

Thyroid Condition  Yes  No

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**FAMILY INFORMATION**

**Mother's Information** (circle one) Mother    Stepmother    Guardian

Please circle one: Married                  Divorced                  Single                  Other: \_\_\_\_\_

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DL #: \_\_\_\_\_

Occupation: \_\_\_\_\_

Primary Number: \_\_\_\_\_ (h/w/c)      Secondary Number: \_\_\_\_\_ (h/w/c)

Address: \_\_\_\_\_

**Father's Information** (circle one) Father    Stepfather    Guardian

Please circle one: Married                  Divorced                  Single                  Other: \_\_\_\_\_

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DL #: \_\_\_\_\_

Occupation: \_\_\_\_\_

Primary Number: \_\_\_\_\_ (h/w/c)      Secondary Number: \_\_\_\_\_ (h/w/c)

Address: \_\_\_\_\_

**Person Responsible for Account**

Please fill out only if different from above

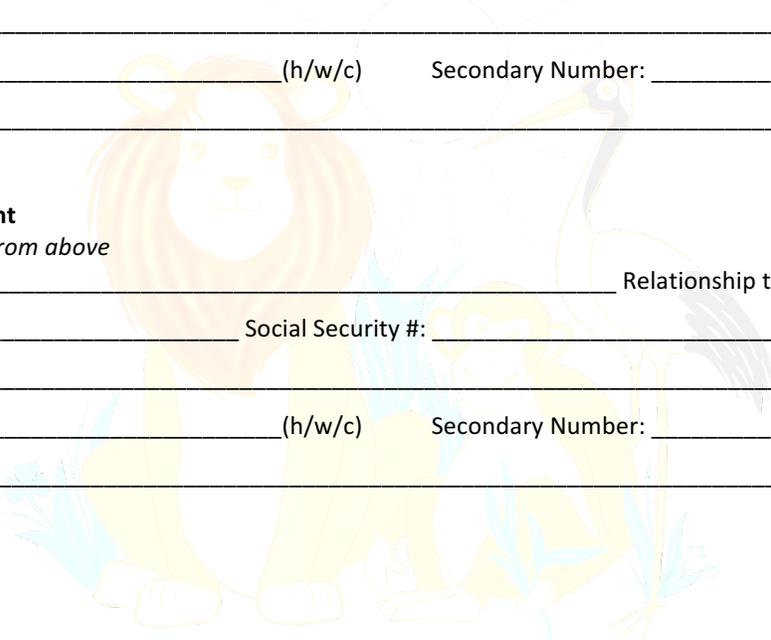
Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DL #: \_\_\_\_\_

Occupation: \_\_\_\_\_

Primary Number: \_\_\_\_\_ (h/w/c)      Secondary Number: \_\_\_\_\_ (h/w/c)

Address: \_\_\_\_\_



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## **INSURANCE INFORMATION**

### **PRIMARY DENTAL INSURANCE INFORMATION**

*Please remember that we use this information to submit claims on your behalf. We are not responsible for knowing your insurance plans frequencies and limitations. Dr. Crane will recommend treatment that is necessary for your child based on their needs, not on your insurance's frequencies and limitations.*

Dental Insurance Company Name: \_\_\_\_\_

Name of Insurance Policy Holder: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Employer Name or Insurance Group Name: \_\_\_\_\_

Insurance Group Number: \_\_\_\_\_ Policy Holder's ID Number: \_\_\_\_\_

### **SECONDARY DENTAL INSURANCE INFORMATION**

Dental Insurance Company Name: \_\_\_\_\_

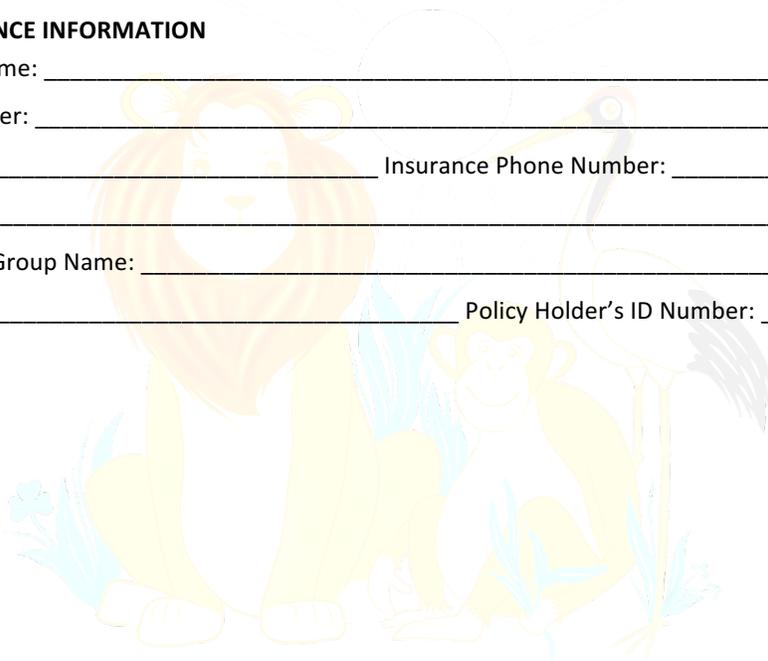
Name of Insurance Policy Holder: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Employer Name or Insurance Group Name: \_\_\_\_\_

Insurance Group Number: \_\_\_\_\_ Policy Holder's ID Number: \_\_\_\_\_



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## **Authorization for Appointments**

*Please be aware that for any appointment in our office we must have authorization for anyone other than a parent or legal guardian to bring the child.*

For future appointments, I hereby authorize the following individuals to bring my child for dental treatment in my absence. They are authorized to sign any necessary documents. This person is authorized to be updated on all dental and medical information regarding my child from this appointment date, and any date in the past. I also understand that I am giving this person the responsibility to relay information from the appointment to myself and/or my spouse.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### **\*Please read and initial the following statements\*\***

\_\_\_\_\_ To the best of my knowledge, all of the preceding answers and information are true and correct. If the patient ever has any change in their health, I will inform Dr. Crane at the next appointment without fail.

\_\_\_\_\_ I hereby authorize Crane Pediatric Dentistry to file claims and release any necessary information to my insurance company. I also hereby authorize assignment of benefits from my insurance company to Crane Pediatric Dentistry. I understand and take full responsibility for any service that is not covered or not paid for by my insurance and/or any service rendered by Crane Pediatric Dentistry.

Signature of Parent/Guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

