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? _____

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□ 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: _____