CHILDREN'S DENTAL CARE OF NORTHWEST INDIANA

Barbara J. Merlo, DDS, MS

-PATIENT INFORMATION-

Patient's Name _____ Social Security # _____

Preferred Name _____ Gender_____ Birthdate _____ Age _____

Address _____ City/State/Zip _____ Cell Phone _____

School _____ Grade _____ Favorite Toys/Hobbies/Sports_____

-MEDICAL HISTORY-

Pediatrician/Family Physician _____ Phone #_____

Please check any of the following that the patient/your child may have had or currently has:

- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Behavior Issues
- ☐ Blood Disorders/Bruising
- ☐ Bleeding Disorders
- ☐ Brain Injury
- ☐ Cancer*
- ☐ Cerebral Palsy
- ☐ Congenital Birth Defects
- ☐ COVID-19
- ☐ Diabetes
- ☐ Ears or Hearing Problems
- ☐ Eating disorders
- ☐ Eye Problems
- ☐ Emotional Problems
- ☐ Endocrine/Hormonal Disorders
- ☐ Epilepsy
- ☐ GI Problems/Reflux
- ☐ Handicaps/Disabilities
- ☐ Headaches
- ☐ Heart Murmur*
- ☐ Heart Disease*
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney or Bladder Problems
- ☐ Lactose Intolerance
- ☐ Learning Disorders
- ☐ Liver
- ☐ Lung(s)
- ☐ Mental Disability
- ☐ Pervasive Development Disorder
- ☐ Pneumonia
- ☐ Pregnancy
- ☐ Rheumatic Fever*
- ☐ Seizures
- ☐ Shunts*
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Skin Problems
- ☐ Speech Disorders
- ☐ Thyroid
- ☐ Transfusions
- ☐ Transplants
- ☐ Tuberculosis
- ☐ Other

Please explain the items checked above_____

*Does the patient/your child require antibiotic premedication prior to dental procedures? ☐ Yes ☐ No

If yes, explain _____

Please check regarding the patient/your child:

- ☐ Receives regular medical exams? Date of last exam _____
- ☐ Under medical care for treatment? If yes, explain _____
- ☐ Premature?
- ☐ Very ill or grew slowly in first year?
- ☐ Taking any medications?* List below
- ☐ Up-to-date on required vaccinations?
- ☐ Allergic to any medications? If yes, explain _____
- ☐ Allergic to latex, food, dyes, or other? If yes, explain _____
- ☐ Hospitalization? Date & Reason _____
- ☐ Surgery? Date & Reason _____
- ☐ Reaction to local anesthetic?
- ☐ Blood transfusion? Date & Reason _____
- ☐ Tonsils or adenoids removed?
- ☐ Substance abuse?
- ☐ Chews or smokes tobacco or vaping?
- ☐ Oral piercings or tattoos?
- ☐ Adopted?

*Please list all medications _____

Please list any other significant medical history pertaining to the patient/your child or his/her family _____

-DENTAL HISTORY-

Reason for today's visit _____

Is this the patient's/your child's first visit to the dentist? ☐ Yes ☐ No

If no, name of previous dentist _____ Reason for visit(s) _____ Last dental visit _____

Please check regarding the patient/your child:

- ☐ Breast or bottle fed past one year?
- ☐ Slept with bottle or bedtime nursing?
- ☐ Dental x-rays?
- ☐ Toothache or oral pain?
- ☐ Injuries to the teeth, mouth, or jaws?
- ☐ Mouth sores or fever blisters?
- ☐ Cavities/decayed teeth?
- ☐ Clinching/grinding teeth?
- ☐ Jaw joint (TMJ) problems?
- ☐ Finger, thumb, lip, pacifier, or other habit?
- ☐ Excessive gagging?
- ☐ Mouth breathing or snoring?
- ☐ Brushes teeth? ☐ Alone ☐ With adult
- ☐ Brushes teeth before bed?
- ☐ Flosses teeth?
- ☐ Fluoride toothpaste?
- ☐ Fluoride rinse?
- ☐ Fluoride supplement?
- ☐ Water source? ☐ City ☐ Well ☐ Bottled ☐ Filtered
- ☐ Fluoride: ☐ Tap water? ☐ Bottled water?
- ☐ Diet high in sugars or starches?
- ☐ Gummy vitamins or fruit snacks?
- ☐ Fruit juices, soda pop, or sports drinks?

What is the patient's/your child's typical reaction to dental or medical care? _____

Has the patient/your child experienced any unfavorable reaction to previous dental or medical care? ☐ Yes ☐ No

If yes, explain _____

How would you evaluate your child's progress in school? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are there any other factors about the patient/your child that you feel would help us provide better care? _____

_____

-PLEASE COMPLETE REVERSE SIDE-

-REGISTRATION INFORMATION-

Father's/Guardian's Name _____ Relationship, if not Father _____ Birthdate _____

Social Security # _____ Email _____ Cell Phone _____

Address _____ City/State/Zip _____ Home Phone _____

Employer _____ Present Position _____ How Long? _____

Address _____ City/State/Zip _____ Work Phone _____

Dental Insurance Company _____ Policy # _____ Group # _____

Address _____ City/State/Zip _____ Ins. Co. Phone _____

Mother's/Guardian's Name _____ Relationship, if not Mother _____ Birthdate _____

Social Security # _____ Email _____ Cell Phone _____

Address _____ City/State/Zip _____ Home Phone _____

Employer _____ Present Position _____ How Long? _____

Address _____ City/State/Zip _____ Work Phone _____

Dental Insurance Company _____ Policy # _____ Group # _____

Address _____ City/State/Zip _____ Ins. Co. Phone _____

Marital status of parent(s)? ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

With whom does the patient live? _____ Name(s) of family members in our practice _____

Whom may we thank for referring the patient/your child to our office? _____

Person(s) financially responsible for patient's account? _____ Relationship _____

Method(s) of Payment: ☐ Insurance ☐ Credit Card ☐ Cash/Check ☐ Medicaid ☐ Other _____

For Automated Reminders: Cell/Mobile # _____ Email _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's/patient's medical status. I give my consent to Children's Dental Care/Barbara J. Merlo, DDS, MS to perform diagnostic procedures and treatment for needed dental services, which may include dental x-rays, local anesthetic, nitrous oxide analgesia (laughing gas), and use of proper and acceptable methods, to complete the treatment necessary. I authorize Children's Dental Care/Barbara J. Merlo, DDS, MS to release information to the insurance company(s) for the purpose of evaluating and administering claims for insurance benefits. I attest to the accuracy of this information.

Parent's/Guardian's Signature _____ Relationship to Patient _____ Date _____

-MEDICAL/DENTAL HISTORY UPDATE-

Please check regarding the patient/your child:

☐ Under medical care at the present time?
If yes, explain _____

☐ Taking any medications?* List below

☐ Up-to-date on required vaccinations?

☐ Allergic to any medications?
If yes, explain _____

☐ Allergic to latex, food, dyes, or other?
If yes, explain _____

☐ Illness, surgery, allergic reaction, or emergency since last visit?
If yes, explain _____

☐ Tooth pain or injury to the mouth/teeth/jaws since last visit?
If yes, explain _____

☐ Significant dietary changes since last visit?
If yes, explain _____

☐ Changes to your child's family, home, or school routines?
If yes, explain _____

☐ Substance abuse?

☐ Chews or smokes tobacco or vaping?

☐ Oral piercings or tattoos?

☐ Change in dental insurance coverage?

*Please list all medications _____

Has the patient/your child been treated by another dentist since last visiting our office? ☐ Yes ☐ No

If yes, explain _____

Are there any other changes in the child's/patient's medical, dental, or family history that should be noted? ☐ Yes ☐ No

If yes, explain _____

Parent's/Guardian's Signature _____ Relationship to Patient _____ Date _____