Dr. Jerry L. Rinehart DDS

2320 North Park Drive, Suite A, Columbus, IN 47203, (812) 379-2024

TELL US ABOUT YOUR CHILD

Child's Name: _____ Today's Date: _____
Last First Mi

Nickname: _____Child's Birth Date: _____Age:_____ ☐Male ☐Female
Home address: _____
Apt/Condo # City State Zip
Home Phone: _____Childs SS #:_____ Child's Cell Phone: _____
Child's School:_____Grade:_____

GENERAL INFORMATION

Who is accompanying the child today? Name: _____Relationship:_____
Do you have legal custody of this child? ☐Yes ☐No Previous Dentist: _____
Last Visit Date: _____ Dentist's Phone Number: _____
Whom may we thank for referring you? _____
Other Siblings: _____
Relative or Friend not living with you: _____ Phone: _____
Address: _____
Apt/Condo # City State Zip
If child is a teen, who is responsible for making appointments?_____ Phone: _____

PARENT'S INFORMATION

Person Responsible for Account: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

☐ **Father** ☐ Step Father ☐ Guardian
Name: _____ Birthdate: _____
Address: _____
_____
SS #: _____ DL #: _____
Work Phone: _____ Ext: _____
Cell Phone: _____
Email: _____
Employer: _____
Employer Address: _____
If you have dental insurance coverage for this child, please fill out below:
Insurance Co. Name: _____
Insurance Address: _____
Insurance Phone: _____
Group # (Plan or Policy #): _____

☐ **Mother** ☐ Step Mother ☐ Guardian
Name: _____Birthdate: _____
Address: _____
_____
SS #: _____ DL #: _____
Work Phone: _____ Ext: _____
Cell Phone: _____
Email: _____
Employer: _____
Employer Address: _____
If you have dental insurance coverage for this child, please fill out below:
Insurance Co. Name: _____
Insurance Address: _____
Insurance Phone: _____
Group # (Plan or Policy #): _____

RELEASE

I certify that my child is covered by _____ Insurance Company and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying my co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment and benefits I authorize the use of this signature on all my insurance submissions, whether manual or electronic. If my account becomes seriously delinquent, I agree to pay the $75.00 charge associated with the collection fees.

Signature of Parent or Guardian: _____ Date: _____

DENTAL HISTORY

WHY DID YOU BRING THIS CHILD TO THE DENTIST TODAY?_____

_____

_____

Has this child ever taken diet pills such as Phen-Phen? ☐ Yes ☐ No
(also known as Redux and Pondmin) If so, when? _____

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Does the child require antibiotics before dental Treatment? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's physician: _____

Phone #: _____ Date of last Visit: _____

Is the child currently under the care of a physician? _____

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all prescriptions/over the counter or herbal supplement drugs that the child is currently taking:_____

_____

Is your child allergic to any of the following:

☐ Yes / No ☐ Latex ☐ Yes / No ☐ Metals/Nickel ☐ Yes / No ☐ Plastic
☐ Yes / No ☐ Codeine ☐ Yes / No ☐ Antibiotics ☐ Yes / No ☐ Aspirin
☐ Yes / No ☐ Dental Anesthetics

Please list any other allergies that your child has:

_____

_____

MEDICAL HISTORY

HAS YOUR CHILD EXPERIENCED THE FOLLOWING MEDICAL PROBLEMS?

☐ Y ☐ N	Abnormal Bleeding	Y ☐ N ☐	Heart Murmur
☐ Y ☐ N	ADD/ADHD	Y ☐ N ☐	Hepatitis
☐ Y ☐ N	AIDS/HIV+	Y ☐ N ☐	High Blood Pressure
☐ Y ☐ N	Anemia	Y ☐ N ☐	Hives
☐ Y ☐ N	Hospital stays/operations	Y ☐ N ☐	Kidney Problems
☐ Y ☐ N	Artificial bones/joints/valves	Y ☐ N ☐	Liver Problems
☐ Y ☐ N	Asthma	Y ☐ N ☐	Low Blood Pressure
☐ Y ☐ N	Cancer	Y ☐ N ☐	Lupus
☐ Y ☐ N	Chicken Pox	Y ☐ N ☐	Measles
☐ Y ☐ N	Congenital Heart Defect	Y ☐ N ☐	Mitral Valve Prolapse
☐ Y ☐ N	Convulsions	Y ☐ N ☐	Mononucleosis
☐ Y ☐ N	Diabetes	Y ☐ N ☐	Prosthetics
☐ Y ☐ N	Epilepsy	Y ☐ N ☐	Rheumatic Fever
☐ Y ☐ N	Exposed to HIV but negative	Y ☐ N ☐	Scarlet Fever
☐ Y ☐ N	Handicaps/Disabilities	Y ☐ N ☐	Skin Rash
☐ Y ☐ N	Hearing impairment	Y ☐ N ☐	Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the doctor in private? ☐ Yes ☐ No

Please list any serious medical problems the child experiences/ed:

_____

_____

Is your child taking birth control pills? ☐ Yes ☐ No

Is your child pregnant? ☐ Yes ☐ No ☐ Unsure

Week#_____

Is your child nursing? ☐ Yes ☐ No

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian: _____ Date: _____