Dean C. Brandon, DMD
Pediatric Dentist

Richard M. Butler, Jr., DDS
Pediatric Dentist

Todd L. Lackey, DDS
Pediatric Dentist

Marc Masterson, DDS
Pediatric Dentist

Geetha Thirumala, DMD
Pediatric Dentist

Paul W. Sproul, DMD, MS
Orthodontist

Kevin D. Tesseneer, DMD, MS
Orthodontist

Alabama Pediatric Dental Associates & Orthodontics

4001 Balmoral Drive, Huntsville (256) 539-7447 **24 Hughes Road, Madison (256) 772-7373** **2699 Sandlin Road, Suite B-7, Decatur (256) 280-9755**

Child's Information

Date ____/____/____

Child's Name _____ Preferred Name _____
(Last) (First) (Middle)

Date of Birth ____/____/____ ☐ Male ☐ Female Social Security # ____-____-____

Child's Address _____ Child's Home # ____-____-____

City _____ State ____ Zip _____

School Attending _____ Grade ____ Child's E-Mail _____

Child's Physician _____ Emergency Contact _____ Phone #____-____-____

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

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Father's Information ☐ Parent/Guardian ☐ Step-Father

Name _____ Address Same As Child's ☐ Yes ☐ No
(Last) (First) (Middle Initial)

Address _____ E-Mail _____

City _____ State ____ Zip ____ Date of Birth ____/____/____

Home # ____-____-____ Cell # ____-____-____ Social Security # ____-____-____

Employer _____ Work # ____-____-____ Ext ____

Mother's Information ☐ Parent/Guardian ☐ Step-Mother

Name _____ Address Same As Child's ☐ Yes ☐ No
(Last) (First) (Middle Initial)

Address _____ E-Mail _____

City _____ State ____ Zip ____ Date of Birth ____/____/____

Home # ____-____-____ Cell # ____-____-____ Social Security # ____-____-____

Employer _____ Work # ____-____-____ Ext ____

Dental Insurance Information

Primary _____

Insured's Name _____

Contract/ID # _____

Group # _____ Policy # _____

Social Security # ____-____-____

Orthodontic Coverage? ☐ Yes ☐ No ☐ Not Sure

Authorization to file Insurance (Initial) _____

Secondary _____

Insured's Name _____

Contract/ID # _____

Group # _____ Policy # _____

Social Security # ____-____-____

Orthodontic Coverage? ☐ Yes ☐ No ☐ Not Sure

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Other Information

Name(s) of any brother(s) or sister(s): _____

Are they current patients? ☐ Yes ☐ No

How did you hear about Alabama Pediatric Dental Associates & Orthodontics?

☐ Former Patient ☐ Hospital ☐ Internet ☐ Insurance ☐ Newspaper ☐ Saw Office ☐ Sibling Is Current Patient

☐ School ☐ T.V. ☐ Staff Referral _____ ☐ Referring Doctor _____

☐ Magazine ☐ Postcard ☐ Way FM 88.1 ☐ Yellow Pages ☐ Other _____

Please list any favorite interests such as favorite toys, activities, or pets that might help us to make your child feel more at home: _____

_____

PAYMENT OF PROFESSIONAL FEES

I understand that I am responsible for the account and payment is due at the conclusion of each appointment. I agree to pay a reasonable attorney's fee if this matter is referred to an attorney for collection. Also, I waive all rights of exemption under the Constitution and laws of Alabama, or any other state, as to personal property. I hereby authorize the procuring of credit reports at any time. **Initial** _____

PERMIT FOR DENTAL SERVICES UPON A MINOR

I, being the parent or guardian of _____ do hereby authorize and request the performance of dental services and to do whatever emergency procedures that the judgment of the doctors may dictate during treatment. I understand some treatments may include the use of nitrous oxide/oxygen analgesia (laughing gas) as deemed necessary by the doctors unless otherwise noted by me. **Initial** _____

Date _____/_____/_____ **Signature** _____ **Relationship** _____

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

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Medical History

Child's Name _____
(Last) (First)

Has your child ever had an unfavorable reaction to any of the following? If YES, please explain.

- ☐ Antibiotics _____
- ☐ Latex _____
- ☐ Local Anesthetic _____
- ☐ Food _____
- ☐ Any metals _____
- ☐ Medication _____
- ☐ Other _____

Has your child had any history of:

- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Diabetes
- ☐ Congenital Heart Defect
- ☐ Tuberculosis (TB)
- ☐ Cancer
- ☐ HIV + / AIDS
- ☐ Kidney/Liver Problems
- ☐ Convulsions/Epilepsy
- ☐ Hepatitis
- ☐ Cerebral Palsy
- ☐ Hearing Impairments
- ☐ Hemophilia
- ☐ Handicaps/Disabilities _____
- ☐ Any Operation(s) _____
- ☐ Other _____

Does your child have any heart condition that requires an antibiotic before any dental procedure? ☐ Yes ☐ No

Please list all medications your child is currently taking: _____

_____

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

Child's Physician _____ Date Last Seen _____/_____/_____

I understand that the information that I have given above is correct to the best of my knowledge and that it will be held in the strictest of confidence. It is also my responsibility as the parent/guardian to inform the office of any changes in my child's medical status.

Signature _____ **Date** _____/_____/_____

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Dental History

Child's Name _____
(Last) (First)

What is the purpose of your child's dental visit with us today?

☐ Check up & Cleaning ☐ Exam Only ☐ Child's 1st Visit to Dentist
☐ Mouth or Tooth pain ☐ 2nd Opinion ☐ Trauma or Accident to Teeth/Gums
☐ Orthodontics ☐ Other _____

When was your child's last dental visit? _____/_____/_____
(Approximate Date)

Has your child had any history of:

☐ Toothaches ☐ Tongue Thrusts ☐ Pacifier Use ☐ Lip Sucking/Biting
☐ TMJ (jaw pain) ☐ Bleeding Gums ☐ Nail Biting ☐ Clenching/Grinding
☐ Thumb/Finger Sucking ☐ Sensitivity to Cold/Hot ☐ Trauma to Tooth/Face/Chin

Has your child ever had an unfavorable experience with any previous dental work before? ☐ Yes ☐ No

If yes, please explain _____

_____

Does your child:

Brush his/her teeth daily? ☐ Yes ☐ No Floss his/her teeth daily? ☐ Yes ☐ No

Has your child been seen by an orthodontist? ☐ Yes ☐ No Date Seen _____/_____/_____

I understand that the information that I have given above is correct to the best of my knowledge and that it will be held in the strictest of confidence. It is also my responsibility as the parent/guardian to inform the office of any changes in my child's dental status.

Signature _____ **Date** _____/_____/_____