| Ketan Sukkawala, DDS | Lawrence Kalke, DMD | Brian Barras, DDS, MS | John Case, DDS, MS |
1103 Rock Prairie Road Ste. 1001 ● College Station, Texas 77845 ● 979.694.5200
1704 S Blue Bell Road ● Brenham, Texas 77833 ● 979.353.0869

Date: _____

Patient Information

Child's Name:_____ Address:_____

Preferred Name:_____ City:_____State:_____Zip:_____

Gender (Circle): Male Female Home Phone:_____

Child's DOB:____/____/____ Age:_____ Email:_____

Sibling(s):_____

Parent Information

Marital Status: Single/Married/Separated/Divorced/Coupled

Check: ☐ Mother ☐ Step Mother ☐ Guardian

Name:_____

Birthday:____/____/_____ SSN#: _____

Cell Phone:_____

Work Phone:_____

Check: ☐ Father ☐ Step Father ☐ Guardian

Name:_____

Birthday:____/____/_____ SSN#: _____

Cell Phone:_____

Work Phone:_____

Today's Visit

Who accompanied the child today?

Name:_____ Relation: _____

Do you have legal custody of this child? Yes No Reason for visit:_____

Whom may we thank for referring you to our practice?
☐ Doctor ☐ Friend ☐ Family ☐ Yellow Pages ☐ Internet
☐ Location ☐ Advertisement ☐ Other
Name:_____

Method of Payment (not including Insurance):

☐ Check ☐ Cash ☐ Credit Card ☐ Care Credit

Child's Name: _____

MEDICAL HISTORY

Check all that apply to your child:

□ Abnormal Bleeding/Bruising
□ HIV/AIDS
□ Anemia
□ Asthma/Breathing Problems
□ Autism Spectrum Disorder
□ Behavior/Emotional Problems
□ Bladder/Kidney Problems
□ Cerebral Palsy
□ Chemotherapy
□ Cleft Lip and/or Palate
□ Convulsions/Seizures/Epilepsy
□ Cystic Fibrosis
□ Diabetes
□ Down syndrome
□ Ear Infections
□ Fainting
□ Hearing Problems
□ Heart Murmur
□ Heart Problems
  □ Antibiotics required (Pre-med)
□ Hepatitis
□ Hyperactivity (ADD, ADHD)
□ Immune Problems
□ Learning Disorders
□ Liver Disorders
□ Malignancy (Cancer)
□ Muscular Dystrophy
□ Radiation Therapy
□ Sickle Cell Anemia
□ Sickle Cell Trait
□ Sleep Apnea
□ Stomach Problems
□ Syndromes (please specify)
□ Thyroid Problems
□ Tuberculosis
□ Vision Problems

□Check if none of the above apply to your child

--Does your child have any medical history or problem(s) not listed above? Please explain.

_____

--Does your child have any of the following allergies? (Check ALL that apply)

□Latex □Penicillin/Amoxicillin □Sulfa □ Nickel □Other:_____

□Check if your child does not have any drug allergies

--List all medication(s) that your child currently takes.

_____

--Has your child ever been hospitalized? □ Yes □No

For what reason?_____

--Is your child up to date on immunizations against childhood diseases? □ Yes □No

--Has your child ever had a reaction to or problem with an anesthetic? □ Yes □No

Name of Child's Physician_____

Date of last physical examination_____ Results_____

DENTAL HISTORY

--Is this your child's first visit to the dentist? □ Yes □No

If no, please share with us why you wish to make a change

_____

--If your child has had previous dental visits, how did he/she respond?

_____

--Date of last dental exam_____ Date of last dental x-rays_____

--Does your child have a previous history of any oral habits (Mouth breathing, Pacifier, Thumb sucking, Etc.)

□ Yes □No Please explain._____

--Has your child had any injuries to the mouth or teeth? □ Yes □No

Please explain._____ -

--Has your child had a toothache now or recently? □ Yes □No

Please explain._____

Office use:

ASA I II III

_____ _____

Parent or Guardian Signature Date

Name of Child(ren): _____

CONSENT TO TREATMENT _____(initials)
By my signature, I authorize Brazos Valley Pediatric Dentistry and any of the staff to perform procedures including, but not limited to, prophylaxis (cleaning), taking radiographs or photographs, administering anesthetics, and/or medications, restoring (filling) teeth, extracting (removing) teeth, and other procedures deemed necessary for my child's care after satisfactory review of the treatment plan with me. X-rays, photographs, and other records will remain the property of Brazos Valley Pediatric Dentistry.

INSURANCE _____(initials)
In order to avoid any misunderstanding regarding dental insurance, we wish our parents to know that all professional services rendered are charged directly to the parent or legal guardian. We will file all necessary forms or reports to your insurance company. We do not render our services on the basis that the insurance companies will pay our fees. By signing below, you authorize the release of any information relating to my dental work to insurance companies. Also, you authorize the payment of the dental benefits directly to Brazos Valley Pediatric Dentistry. ***Parents are responsible for any fees the insurance company does not cover.***

PAYMENT POLICIES_____(initials)
Payments for professional services must be made at the time services are rendered unless prior arrangements are made. I understand and agree that I am ultimately responsible for the balance of my child's account. If I fail to meet the requirements you have provided, I know you have no choice, but to turn this matter over to a collection agency as provided by the law.

CONSENT FOR NITROUS OXIDE_____(initials)
There are various methods we use to guide your child's behavior and provide a positive dental experience. Since each child is unique, no list can be complete and other methods may be explained as needed. These methods include: TELL, SHOW, DO/IMAGERY/DISTRACTION/POSITIVE REINFORCEMENT/VOICE CONTROL. In addition to these methods, the use of laughing gas (nitrous oxide) is a safe way to provide dental treatment to children. Laughing gas calms children, but does not put them to sleep or numb their teeth. It has few side effects and lasts only as long as the gas is being given through a nose mask. On rare occasions, the gas can cause an upset stomach and vomiting. Nitrous oxide will only be administered with your permission after discussion of the treatment plan.

PHOTOGRAPH RELEASE_____(initials)
I give permission for the use of my child's name and picture for in-office promotions and our dental website, including Facebook.

NOTICE OF PRIVACY PRACTICES

I, _____(name of parent or legal guardian), have received and reviewed a copy of the Notice of Privacy Practices for Brazos Valley Pediatric Dentistry.

_____ _____
Parent or Guardian Signature Date