Jonathan Shenkin DDS, MPH
Diplomate of the American Board of Pediatric Dentistry
Augusta Pediatric Dentistry
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Tel: 207-622-0303 **Fax: 207-622-0337** www.babi2th.com

Today's Date: _____

Patient Information:

Name: _____
Last First MI

Preferred Name:_____ Sex: Male Female

Birthdate: _____ Age _____

Address_____

_____
City State Zip

Marital Status of Parents:

Married_____ Divorced _____ Separated _____ Single _____

Mother's Information:

Name_____

Mother Stepmother Guardian BIRTHDATE_____/_____/_____

Address_____

_____
City State Zip

Home # _____ Cell# _____

Employer: _____

Occupation:_____

SS #: _____ e-mail: _____

Father's Information:

Name_____

Father Stepfather Guardian BIRTHDATE_____/_____/_____

Address_____

_____
City State Zip

Home # _____ Cell# _____

Employer: _____

Occupation:_____

SS #: _____ e-mail: _____

Dental Information:

How did you hear about our office?_____

Is this your child's first visit to the Dentist? _____

If not what was the date of their last visit? _____

Previous Dentist? _____

Was it a positive experience for your child? _____

If not why? _____

Any injuries to teeth, face or mouth?_____

If **Yes** please explain: _____

Do you or your child have specific concerns? _____

_____

How many times a day does your child brush? _____

How many ounces of juice does your child drink a day? _____

Was your child : Bottle / Breastfed: Until what age? _____

Does your child have any of the following habits?

Yes **No** Lip Sucking/Biting **Yes** **No** Thumb/Finger sucking

Yes **No** Pacifier **Yes** **No** Nail Biting

Yes **No** Tooth Grinding **Yes** **No** Mouth Breather/Snoring

Yes **No** Does your child drink well water?

Yes **No** Is your child taking fluoride supplements?

Yes **No** Is your child using fluoride toothpaste?

Yes **No** Does your child floss his/her teeth daily?

Yes **No** Does an adult assist child with brushing/flossing?

Yes **No** Does your child drink soda?

Yes **No** Do either Parents have untreated tooth decay?

Yes **No** Do either Parents have a history of smoking?

Yes **No** Do we treat any siblings? _____

Describe your Child: Outgoing _____ Shy ____

Stubborn ____ Anxious _____ Frightened _____

Is your child having problems with any of the following?

Cavities Toothache Sensitive Teeth Trauma

Gum Infection Color of Teeth Tooth Alignment

Jaw Joint popping/clicking Other _____

Insurance Information:

Do we have a copy of your Insurance Card? **Yes** **No**

Is your child covered by MaineCare? **Yes** **No**

Dental Ins. Co. Name _____

Subscriber's Name _____

Group/Policy #_____ ID#_____

Signature_____

Date_____ **Relationship** _____

Child's Name_____DOB_____

Medical Information

Child's Physician:_____

Phone # _____ Date of last visit _____

Is your child currently being treated for anything by his/her Physician? **YES** **NO**

If yes, please explain:_____

_____

Please describe the child's current physical health?

Excellent Good Fair Poor

Are Immunizations Current? **YES** **NO**

Please list all medications w/ dosage your child is currently taking: _____

_____

Does your child have any of the following allergies?

Medications	**YES**	**NO**	Food	**YES**	**NO**
Latex	**YES**	**NO**	Other	**YES**	**NO**

If Yes, please list _____

Please describe the reaction: _____

_____

Please answer the following questions regarding your child,

And if the answer is "YES", then explain briefly below:

YES **NO** Prior hospitalizations or surgeries?

YES **NO** Prior General Anesthesia or Sedation?

YES **NO** Congenital (birth) abnormalities?

YES **NO** Infectious disease (measles, chicken pox, HIV)?

YES **NO** Developmental Delays?

_____

_____

_____

Does your child have any medical conditions with the following systems of the body? If so, please explain briefly below.

YES **NO** Heart: (murmur, surgery, malformation, high/low Blood pressure)

YES **NO** Lungs: (asthma, tuberculosis, reactive airway, Cystic fibrosis, RSV)

YES **NO** Gastrointestinal: (GERD/reflux, hepatitis, Jaundice, ulcer, lactose intolerance, dietary Restrictions

YES **NO** Genitourinary: (bladder/kidney infections, Systemic birth control, pregnancy)

YES **NO** Musculoskeletal: (bone/joint problems, arthritis)

YES **NO** Skin: (fever blisters, eczema, rash/hives)

YES **NO** Neurologic: (autism, developmental delay, Seizures, epilepsy, brain injury, cerebral palsy)

YES **NO** Psychiatric: (abuse, ADHD, chemical dependency Emotional disturbance)

YES **NO** Endocrine: (diabetes, hypothyroid, hormonal Problems, growth delay)

YES **NO** Hematologic/Lymphatic/Immunity: (anemia Hemophilia, sickle cell, cancer, immune Disorder, chemotherapy, radiation therapy)

Anything Not Listed please add below:

_____

_____

_____

_____

_____

Who else may bring your child to his/her appointment?

I authorize _____

to present my child _____ for evaluation and treatment in my absence.

I can be contacted at _____

Verification of Information and Consent

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Shenkin and the dental team to examine, clean and provide dental treatment on my child's teeth. I further authorize the taking of dental x-rays as may be considered necessary by Dr. Shenkin to diagnose and/or treat my child's dental problem. I also consent to intraoral and extraoral photographs of my child's mouth to be taken when indicated for clinical purposes. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

_____ _____ _____

Signature Date Relationship

I verbally reviewed the medical/dental information above with the Parent/guardian and patient named herein.

Dr.'s Initials _____ Date _____

Doctor's Comments _____

_____

_____