Melissa Mullane Padgett, DDS

General Dentist Accepting Children

We are pleased to welcome you and your child to our practice! Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Patient Information

Patient Name _____ Preferred Name _____

DOB_____Gender_____ Preferred Phone _____Text? ☐ Y ☐ N

Address _____

Who referred you? _____

Guardian Information

Parent/Guardian's Name _____

Social Security # _____ DOB _____

Address (if different than above) _____

_____

Phone (Home) _____ (Cell)_____

(Work) _____

Email Address _____

Parent/Guardian's Name_____

Social Security # _____ DOB _____

Address (if different than above) _____

_____

Phone (Home) _____ (Cell)_____

(Work) _____

Email Address _____

Dental Insurance Information

Primary: Plan name _____

Subscriber's name _____ Employer _____

Secondary: Plan name _____

Subscriber's name _____ Employer _____

Does the child have dental coverage through the State of Ohio? Medicaid ☐ Yes ☐ No

Caresource ☐ Yes ☐ No United Health Care Community Plan ☐ Yes ☐ No BCMH ☐ Yes ☐ No

If yes, we must have a copy of the card at **EACH VISIT**.

Primary or Secondary coverage (circle one) ID # _____

Signature_____ Date_____ Relationship to patient _____

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Medical History

Child's Name _____ DOB _____

Pediatrician/Medical Physician Name/Phone_____

Specialist (cardiologist, endocrinologist, counselor, etc,) Name/Phone _____

Do you have or have you had any of the following? (Check all that apply)

- ☐ ADD/ADHD
- ☐ Anxiety General
- ☐ Anxiety Dental
- ☐ Asthma
- ☐ Autism/Asperger's
- ☐ Bipolar
- ☐ Bleeding Disorder
- ☐ Cancer/Leukemia
- ☐ Cerebral Palsy
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Epilepsy/Seizures
- ☐ Frequent Ear Infections
- ☐ Frequent Fainting
- ☐ Hearing Difficulties/Deaf
- ☐ Heart Problems
- ☐ Atrial Septal Defect
- ☐ Ventral Septal Defect
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ HIV/AIDS
- ☐ Kidney Problems
- ☐ Learning Disabilities
- ☐ Liver Problems
- ☐ Mental Health Problems
- ☐ Non-verbal (ages 3+)
- ☐ Rheumatoid Arthritis
- ☐ Tonsillitis
- ☐ Other _____

Surgery? Describe_____

Admitted to hospital or over night stay? Describe_____

Medications, vitamins, supplements? Name/s _____

For what ?_____

Allergies: (Check all that apply)

- ☐ Amoxicillin/Penicillin
- ☐ Codeine
- ☐ Latex
- ☐ Food _____
- ☐ Seasonal _____
- ☐ Other Medications _____

Dental History

Bad experience? Y/N Explain_____

Brush teeth _____ times per day/week

Floss teeth _____times per day/week

Injuries to mouth, teeth, head_____

Children under age 5:

Pacifier Y/N Age stopped_____

Bottle Y/N Age stopped_____

Sippy cup Y/N Age stopped_____

Thumb sucking Y/N Age stopped_____

Sleeping with bottle/sippy cup Y/N Age stopped_____

Other info?_____

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Dr. Padgett or her dental team if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian or personal representative of _____(name of minor child) and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental team to perform necessary services for the child named above, including but not limited to radiographs, administration of anesthetics, and administration of nitrous oxide, which are deemed advisable by Dr. Padgett, whether or not I am present when the treatment is rendered.

Signature_____ Date_____ Relationship to patient _____