Dr. Nick A. Prater D.D.S. L.L.C.

Pediatric Dentistry & Orthodontics

Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T/P.T., name of school _____ City _____ State _____

Patient or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's license # _____ Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

How much is your deductible _____ How much have you used _____ Max annual benefit _____

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

Ins. Co. address _____ City _____ State. _____ Zip _____

How much is your deductible _____ How much have you used _____ Max annual benefit _____

X_____ _____

Signature of patient (or parent, if minor) **Patient number**

Dr. Nick A. Prater D.D.S. L.L.C.

Pediatric Dentistry & Orthodontics

Welcome to our office and thank you for choosing us to take care of your child's dental and orthodontic needs. Our goal is to make every child's visit enjoyable and educational. Our practice is based on preventive care. We strive to teach your child good oral care that will enable them to have a beautiful smile that lasts a lifetime. Dr. Prater is the local expert in dentofacial growth and development.

A Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Child's Birthdate: _____ Child's Age: _____

Nickname: _____ Gender: _____

School: _____ Grade: _____

Child's Home #: _____ SS#: _____

Childs Home Address: _____

_____

City State Zip

Email Address: _____

Why did you bring the child to the dentist today?

_____

_____

_____

Has the child ever had a serious/difficult problem associated with previous dental work?

_____

_____

Is the child's home water filtered? _____

Is the child taking fluoridated supplements? _____

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? _____

Does the child brush his/her teeth daily? _____

Floss his/her teeth daily? _____

Child's Physician: _____

Phone#: _____ Date of last visit: _____

Please describe the child's current physical health:

Good _____ Fair _____ Poor _____

Has the child ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? Yes _____ No _____

Has the child ever taken Accutane? Yes _____ No _____

Does/did the child experience any of the following?

Y N	Lip Sucking/Biting	**Y N**	Nursing Bottle Habits
Y N	Nail Biting	**Y N**	Thumb/Finger Sucking
Y N	Tongue Thrusting	**Y N**	Tooth Grinding

C Has the child ever had any of the following medical problems?

Y N	Abnormal Bleeding	Y N	Handicaps / Disabilities
Y N	ADD / ADHD	Y N	Hearing Impairment
Y N	Anemia	Y N	Heart Murmur
Y N	Any Hospital Stays	Y N	Hemophilia
Y N	Any Operations	Y N	Hepatitis
Y N	Artificial Bones/joints/valves	Y N	Hives
Y N	Asthma	Y N	HIV+ / AIDS
Y N	Cancer	Y N	KIdney / Liver Problems
Y N	Chicken Pox	Y N	Measles
Y N	Congenital Heart Defect	Y N	Mononucleosis
Y N	Convulsions	Y N	Rheumatic / Scarlet Fever
Y N	Diabetes	Y N	Sickle Cell Disease / Traits
Y N	Epilepsy	Y N	Skin Rash
Y N	Exposed to HIV, but Neg.	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 discuss any serious medical problems that the child has had:

_____

_____

Please list all drugs that the child is currently taking:

_____

_____

Aside from items listed below, list all drugs/things the child is allergic to:

_____

_____

Latex Yes ____ No ____ **Metals/Nickel** Yes ____ No ____

Plastic Yes ____ No ____ **Food Dyes** Yes ____ No ____

D Who Is Accompanying The Child Today?

Name: _____ **Relation:** _____

Do you have legal custody of this child? Yes _____ No _____

Is child adopted? Yes _____ No _____

Whom may we thank for referring you?

_____

Other siblings seen by us: _____

Previous/Present Dentist: _____

(Please Circle)

Last Visit Date: _____

Parent's Marital Status:

Single _____ Married _____ Divorced _____

Widowed _____ Partnered _____ Separated _____

E Person Responsible For Account

Name: _____ Relation: _____
Billing Address: _____
_____
City State Zip

Wk #: (____)_____ Ext: _____ Hm#: (____)_____
Employer: _____
SS #: _____ DL #: _____

F Parent's Information

Mother _____ Stepmother _____ Guardian _____
Name: _____ Birthdate: ____/____/_____
Email Address: _____
Cell #: (____)_____ Hm#: (____)_____
Employer: _____ Wk#: (____)_____
SS#: _____ DL#: _____

Father _____ Stepfather _____ Guardian _____
Name: _____ Birthdate: ____/____/_____
Email Address: _____
Cell #: (____)_____ Hm #: (____)_____
Employer: _____ Wk #: (____)_____
SS #: _____ DL #: _____

G Primary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: (____)_____
Croup # (Plan, Local, or Policy #): _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: ____/____/____ ID #: _____
Policy Owner's Employer: _____
Employer's Address: _____
Orthodontic Coverage? Yes _____ No _____

H Secondary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: (____)_____
Croup # (Plan, Local, or Policy #): _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: ____/____/____ ID #: _____
Policy Owner's Employer: _____
Employer's Address: _____
Orthodontic Coverage? 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 ADA.