



DESCHUTES
PEDIATRIC DENTISTRY

WELCOME

Please Tell Us A Little About Your Child

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Tell Us About Your Child

Today's Date: _____ Male Female

Name: _____

Nickname: _____ SS#: _____

Birth date: _____ Age: _____

School: _____ Grade: _____

Weight: _____ Height: _____

Home Phone: _____

Home Address: _____

Names of other children in your family seen by us:

Referred By: _____

Would you like to speak with the Doctor privately?

Yes No

Responsible Party Info (Parent or Guardian)

Mother: _____

Home Phone: _____ Cell Phone: _____

Address: _____

Employer: _____

Work Phone: _____

SS#: _____ Birth Date: _____

Father: _____

Home Phone: _____ Cell Phone: _____

Address: _____

Employer: _____

Work Phone: _____

SS#: _____ Birth Date: _____

Emergency Contact

Name: _____

Home Phone: _____ Cell Phone: _____

Relationship To Patient: _____

Primary Insurance

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Group/ID #: _____

Subscriber's Name: _____

Subscriber's SS#: _____

Subscriber's Employer: _____

Relationship to Patient: _____

Secondary Insurance

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Group/ID #: _____

Subscriber's Name: _____

Subscriber's SS#: _____

Subscriber's Employer: _____

Relationship to Patient: _____

Dental History

What are your primary dental concerns for your child? _____

Is this your child's first dental visit? Yes No

Is your child taking fluoride? Yes No

If Yes: Tablets Drops

Name of previous dentist: _____

Date of last dental exam: _____

Has your child ever injured their teeth or jaws?
 No Yes If yes, when? _____

Does your child have a history of the following:
Nursing/Bottle Habits Past Present
Thumb/Finger Sucking Past Present
Pacifier Past Present
Teeth Grinding/Clenching Past Present

Has your child ever had an unfavorable medical/
dental experience? Please explain: _____

How do you think your child will act at the dentist
office?: _____

Medical History

Who is your child's primary care physician?
Name: _____ Phone: _____

Is your child currently under their
care for a medical problem? Yes No

Please Explain: _____

Is your child currently taking any prescription or over
the counter medications? Yes No

Please Explain: _____

Has your child ever been hospitalized
or had surgery? Yes No

Please Explain: _____

Is your child allergic to any medications/foods?
 Yes No

Please Explain: _____

Is your child allergic/sensitive to latex, acrylics or
metals? Yes No

Please Explain: _____

Are your child's immunizations up to date?
 Yes No

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

- AIDS/HIV Yes No
- Anemia/Sickle cell Yes No
- Arthritis Yes No
- Asthma (Severity: _____) Yes No
- Autism Yes No
- Bladder condition Yes No
- Blood disease Yes No
- Blood transfusion Yes No
- Birth defects Yes No
- Bone/Joint problem Yes No
- Brain injury Yes No
- Bruise easily Yes No
- Cancer, malignancy, chemotherapy, or radiation Yes No
- Please explain: _____
- Cerebral palsy Yes No
- Child abuse/neglect Yes No
- Chronic adenoid/tonsil issues Yes No
- Chronic ear infections Yes No
- Cleft lip/palate Yes No
- Congenital heart defect Yes No
- Developmentally delayed Yes No
- Diabetes Yes No
- Epilepsy/seizures Yes No
- Fainting/dizziness Yes No
- Growth/development problems Yes No
- Heart surgery/murmur/defects Yes No
- Hearing/speech problems Yes No
- Hemophilia Yes No
- Hepatitis/Liver disease Yes No
- High blood pressure Yes No
- Hyperactivity/ADD Yes No
- Kidney disease Yes No
- Mental delay/disability Yes No
- Neurological disorder Yes No
- Premature birth Yes No
- Rheumatic fever Yes No
- Tuberculosis Yes No
- Other: _____

I authorize Deschutes Pediatric Dentistry to administer necessary medications and perform such diagnostic, photographic, preventive, therapeutic and restorative procedures as may be necessary for proper dental health and care. I understand that no treatment will be started until such recommended treatment, time involved, and financial investment has been discussed with me by either Dr. Steve Christensen, Dr. Stephanie Christensen or one of their staff members. The information on this page and the dental/medical history is correct to the best of my knowledge. I grant Deschutes Pediatric Dentistry the right to release my child's dental/medical histories and other information about my child's dental treatment to third party payers and/or other health professionals. I attest that I have answered this dental/medical history to the best of my knowledge and have disclosed my child's complete health history on this document.

Parent/Guardian Signature: _____ Today's Date: _____

Dentist Signature: _____ Today's Date: _____

Reviewed on: _____ Reviewed on: _____ Reviewed on: _____ Reviewed on: _____