Woodlands Pediatric Dentistry P.C.

Scott A. Andersen, D.D.S.
Tab R. Imdacha, D.D.S.

Child's Name: _____ DOB: _____ Age: _____
Nickname: _____ Gender: Male _____ Female _____
Child's Physician: _____ Phone #: _____
Family Dentist: _____ Phone #: _____
Is your child in good general health? YES _____ NO _____
Is your child seen routinely by a physician? YES _____ NO _____
If YES, Why... _____

Name of person who referred you to our office: _____
Circle One: Dentist Physician Friend Internet Other

Has your child had any history of:	YES	NO
Seizures	_____	_____
Blood Disorder	_____	_____
Cerebral Palsy	_____	_____
Heart Trouble	_____	_____
Allergies	_____	_____
Diabetes	_____	_____
Asthma	_____	_____
Kidney Disorders	_____	_____
Liver Disorders	_____	_____
Developmental Delays	_____	_____

Is your child taking medicine? _____ If so, for what? _____
Has your child had any unfavorable reactions or allergies to any drugs, anesthetics, or latex? ____
If yes, please indicate medication and reaction _____

Has your child had any history of:	YES	NO	CURRENT
Snoring	_____	_____	_____
Teeth Grinding	_____	_____	_____
Thumbsucking	_____	_____	_____
Fingersucking	_____	_____	_____
Prolonged breast or bottle feeding	_____	_____	_____
Pacifier past age 2	_____	_____	_____

CHIEF PURPOSE OF THIS DENTAL VISIT _____
IS YOUR CHILD IN PAIN NOW? _____
HAS YOUR CHILD HAD ANY PREVIOUS DENTAL TREATMENT? _____
HAS YOUR CHILD HAD ANY UNFAVORABLE DENTAL / MEDICAL EXPERIENCE? ___
IF YES, PLEASE EXPLAIN: _____

Contact Information

Child's Home Address: _____

City: _____ Zip: _____

Phone: (Please Check Preferred Contact Number)

○ Mom Cell: _____ ○ Dad Cell: _____

○ Home: _____ ○ Work: _____

Email Adress: (Please Check Preferred Email)

○ Mom: _____ ○ Dad: _____

Emergency Contact:

Name: _____ Phone: _____

Insurance Information:

Father's Name: _____ SS#: _____ DOB: _____

Insurance Company: _____ Group#: _____

Employer: _____

Mother's Name: _____ SS#: _____

Insurance Company: _____ Group#: _____

Employer: _____

List brothers or sisters currently in our practice

_____

_____

Parent's Signature _____ Date _____

Relationship if other than parent signing _____

It is our office policy to bill your insurance carrier as a courtesy to you. You are ultimately responsible for your account in any event that the insurance company does not pay the balance within 60 days