WELCOME

Date_____

PEDIATRIC DENTIST OF KATY 24022 Cinco Village Center Blvd., Suite 210, Katy, TX 77494 281-693-9100

Patients' Name_____ Preferred Name_____
Last, First, Middle Initial

M F Circle one

Date of Birth_____ *Referred By*_____

School Child Attends_____ Grade_____

Name of Brothers / Sisters_____

Mailing Address_____ Social Security #_____

City/State/Zip_____ Home Phone_____

Mother's Name_____ Home Phone_____

Address_____ Cell Phone_____

City/State/Zip_____ Work Phone_____

Date of Birth_____ Social Security #_____

Drivers License Number_____ Email Address_____

Employer_____ Occupation_____

Employer Address_____ City/State/Zip_____

Father's Name_____ Home Phone_____

Address_____ Cell Phone_____

City/State/Zip_____ Work Phone_____

Date of Birth_____ Social Security #_____

Drivers License Number_____ Email Address_____

Employer_____ Occupation_____

Employer Address_____ City/State/Zip_____

Person responsible for the account_____ Phone_____

Is your child eligible to receive dental coverage through a publicly funded program such as Medicaid?_____

If you have private or Employer sponsored Dental Insurance, please complete the following

Employee Name_____ Employee Name_____

Date of Birth_____ Date of Birth_____

Policy Number_____ Policy Number_____

Employer Name_____ Employer Name_____

Group Number_____ Group Number_____

Insurance Company Name_____ Insurance Company Name_____

Pediatrician or Family Doctor_____ Date of Late Visit_____

Is your child currently under the care of a physician?_____ If yes, please explain_____

_____

Is your child currently taking any medication?_____ If yes, please specify medication and dosage

_____

Has your child ever been hospitalized or treated in an emergency room?_____

If yes, please provide details_____

List foods or medications to which your child is allergic_____

Does your child have a history of any of the following? If Yes, please check and explain.

☐ Anemia	☐ Seizure or convulsions	☐ HIV / AIDS
☐ Asthma	☐ Speech/hearing problems	☐ Nerve or Brain injury
☐ Bleeding disorder	☐ Kidney/liver disorder	☐ Tuberculosis
☐ Cerebral Palsy	☐ Rheumatic Fever	☐ Handicap/Disabilities
☐ Heart Murmur	☐ Hepatitis	☐ Diabetes
☐ Congenital Heart Defect	☐ Cancer	☐ Other

Please explain any yes answers_____

_____

Date_____ Reviewed by_____

Dental History

Has your child been to a dentist before?_____ Date (approximate)_____

Name of child's previous dentist_____

Name of parent's dentist_____

Has your child had any unfavorable experiences in a medical or dental office?_____

If yes, please explain_____

Is your child's drinking water fluoridated?_____

Does your child receive a fluoride supplement?_____

Does your child suck his/her finger or thumb?_____

Has you child received any injuries to his/her teeth or jaws?_____ If yes, please explain:

_____

Any other concerns:_____

_____

Consent

I authorize Dr. Po and his staff to perform upon my child (or legal ward) dental treatment, to include the use of topical fluoride, dental radiographs (X-Rays) and local anesthetic, as appropriate.

Signature_____ Date_____