Dr. Jared Welch
(480) 917-9339
www.tikiteeth.com

PATIENT INFORMATION

DATE: ______________________

Last Name______________________ First Name ______________________ Middle I ____ Gender ________

Prefers to be addressed by ______________________ Date of Birth _____/_____/_____ Age ______________

Address______________________________________ Apt# ______________________

City ____________________ State ________ Zip _______ Home Telephone ______________________

Emergency Contact: Name______________________ Telephone* ______________________

Other family members treated at this office ______________________________________

PARENTAL INFORMATION

Mother

Name______________________________

Date of Birth _____/_____/_____

Social Security# ______________________

Cell Phone#______________________

Email ______________________

Single _______ Married ______

Widowed ______ Divorced _____

Separated _____ Guardian _____

Employer ______________________

Address ______________________

Telephone______________________

Complete if *DIFFERENT*

Home Address ______________________

City___________State___ Zip ______________

Home Telephone ______________________

Father

Name______________________________

Date of Birth _____/_____/_____

Social Security# ______________________

Cell Phone#______________________

Email ______________________

Single _______ Married ______

Widowed ______ Divorced _____

Separated _____ Guardian _____

Employer ______________________

Address ______________________

Telephone ______________________

Complete if *DIFFERENT* from Patient's home information:

Home Address ______________________

City___________State___ Zip ______________

Home Telephone ______________________

DENTAL INSURANCE INFORMATION

Primary Insurance

Company ______________________

Address______________________

City___________State___ Zip ______________

Insurance Telephone ______________________

Policy/ Group# ______________________

Policy Holder______________________

Relationship to Patient______________________

Secondary Insurance

Company ______________________

Address______________________

City___________State___ Zip ______________

Insurance Telephone ______________________

Policy/ Group# ______________________

Policy Holder______________________

Relationship to Patient______________________

REFERRAL INFORMATION

How did you hear about our office?

____

Patient's Name ______________________________ *D.O.B.* ______________________________

DENTAL HISTORY

Previous dentist (if any) ____________________ **Date of last dental exam** ____________________

What concerns you most about your child's dental health? ______________________________

Does your child have dental pain? Y _____ N ____ Level of pain (1-10) ____________________

Mouth habits? (Please cheek) Thumb sucking _______ Pacifier _______ Mouth Breather _______

Still on bottle _______ Finger habit _______ Tooth grinding _______ None _______

Has your child had a negative dental experience in the past? ______________________________

If yes, please explain ______________________________

How often does your child brush? ____________________ **Floss?** ____________________

Has your child received fluoride supplements? Y _____ N ____ **If yes, what kind?** ____________________

Are you happy with the appearance of your child's teeth? ______________________________

MEDICAL HISTORY

Name/Practice Name of childs pediatrician ____________________ **Phone #** ____________________

Is your child under the care of a physician at this time? Y _____ N ____

Explain: ______________________________

Has your child ever had a serious illness or been hospitalized? Y _____ N ____ Date: ____________________

Explain: ______________________________

Has you child ever had general anesthesia? Y _____ N ____

Explain: ______________________________

Are all your child's immunizations current? Y _____ N ____

Has your child ever been advised to take an antibiotic prior to any dental treatments? Y _____ N ____

If yes, antibiotic name and method: ______________________________

Is your child taking any medication? Y _____ N ____ If yes, what: ______________________________

Does your child have allergies? (medications, food, latex, seasonal etc.) Y _____ N ____

If yes, what: ______________________________

Please answer the following. Has your child ever had a history of:

Y	N		Y	N	
❑	❑	ADD/ADHD	❑	❑	Heart Condition (type? ________)
❑	❑	AIDS or H.I.V. Positive	❑	❑	Heart Murmur
❑	❑	Anemia	❑	❑	Heart Pacemaker
❑	❑	Artificial Heart Valve	❑	❑	Heart Surgery date: ________
❑	❑	Asthma	❑	❑	Hemophilia (type? ________)
❑	❑	Autism	❑	❑	Hepatitis (type? ________)
❑	❑	Birth defects	❑	❑	Jaw Pain
❑	❑	Blood Disorders /Bleeding Problems ________	❑	❑	Kidney Trouble
❑	❑	Brain Injury	❑	❑	Leukemia
❑	❑	Cancer	❑	❑	Liver Disease
❑	❑	Cerebral Palsy	❑	❑	Psychiatric Treatment
❑	❑	Cleft lip/Palate	❑	❑	Respiratory Lung Disease
❑	❑	Developmental Delayed	❑	❑	Rheumatic Fever
❑	❑	Diabetes	❑	❑	Scoliosis
❑	❑	Earaches	❑	❑	Sickle Cell
❑	❑	Emotional Problems	❑	❑	Speech Problems
❑	❑	Epilepsy (seizures)	❑	❑	Syndrome (type? ________)
❑	❑	Fainting Spells	❑	❑	Tonsillitis
❑	❑	Headaches	❑	❑	Tuberculosis
❑	❑	Hearing/Sight Impaired	❑	❑	Ulcers

❑ Other: ______________________________

Is there any other information that we should know about your child's health? ______________________________

I certify that the information given is correct and give consent to Arizona Pediatric Dental Care to treat my child.

Signature ____________________ Date ____________________

(Please Circle One) Parent Guardian Other

Reviewed By ____________________ Date ____________________

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