ACORN DENTAL PEDIATRIC CLINIC

If you choose to not disclose the needed information for your child's account we will not be able to bill Medicaid and you will be responsible for your child's bill.

Child's Name: ______________________ Nickname: ______________

Date of Birth: ______________ SS#: __________________ Sex: M / F

Mother's Name: ________________ Father's Name: ________________

Who is responsible for the child's account: __________________________

Address: ________________________ City: ____________ Zip: _______

Phone #: (___) ___-________ Race: ____________

Medicaid # ______________________________ or Self Pay

Financial Screening: # of people in home: _____ Monthly Income: _________

Health History

Does your child have or has your child ever had any of the following conditions:

Y	N	Condition
		Seasonal Allergies
		Anemia
		Asthma
		Bleeding Problems
		Cancer
		Cerebral Palsy
		Cleft Lip & Palate
		Delayed Speech Development
		Developmentally Delayed
		Diabetes
		A.D.D
		Fainting/Dizziness
		Hearing Loss/Impairment

Y	N	Condition
		Heart Condition/Murmur
		Autism
		Infectious Diseases
		Jaundice
		Kidney Disease
		Liver Disease
		Pregnant
		Psychiatric Care
		Rheumatic Fever
		Seizures
		Sickle Cell Anemia
		A.D.H.D
		Other ______________

Is your child seeing a physician now? _____ Why? __________________________

Physician's Name: ______________________________

Is your child on any medications? _____ If so, Please List: ____________________

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List any medication allergies: ____

Has your child been hospitalized? ____ When? ____________ Why? ____________________

Dental History

Y	N		Y	N	
		Has your child ever had a toothache?			Has your child received a blow to the teeth?
		Does brushing cause the gums to bleed?			Does your child take a bottle at bedtime?
		Any unhappy dental visits?			Do you assist your child in brushing teeth?
		Do you have any concerns today? ______________________________			

Main Reason for today's visit: ____

When was the last dental visit? ____________________________________

Behavior Profile

How has your child acted to past medical and dental procedures?

( ) Very Good ( ) Moderately Good ( ) Moderately Poor ( ) Very Poor

How do you expect your child to act in the dental chair?

( ) Very Good ( ) Moderately Good ( ) Moderately Poor ( ) Very Poor

Who referred you to ACORN? Family/Friend Media School Church Outreach

Doctor/Dentist Other____________________

______________________________ ________________

Parent/ Guardian Signature Date