Aimee Snell-Killam DDS MS
Ryann McLennan DMD
Pediatric Dentist
www.bigbluedental.com

Today's Date_____

1 Tell Us About Your Child(ren)

Full Name_____
Nickname_____ O Male O Female
Date of Birth ___/____/_____ Age_____
School_____ Grade_____

Full Name_____
Nickname_____ O Male O Female
Date of Birth ___/____/_____ Age_____
School_____ Grade_____

Full Name_____
Nickname_____ O Male O Female
Date of Birth ___/____/_____ Age_____
School_____ Grade_____

2 Parent/Guardian/Guarantor Information

Full Name_____
Relationship to Child_____
Date of Birth _____ SSN_____
Address_____
City_____ State_____ Zip_____
Cell Phone (____)_____
Home Phone (____)_____
Employer_____
Occupation_____
Work Phone (____)_____ OK to call Y / N
Drivers License #_____
Email address_____
O Single O Married O Divorced O Widowed

3 Parent/Guardian Information

Full Name_____
Relationship to Child_____
Date of Birth _____ SSN_____
Address_____
City_____ State_____ Zip_____
Cell Phone (____)_____
Home Phone (____)_____
Employer_____
Occupation_____
Work Phone (____)_____ OK to call Y / N
Drivers License #_____
Email address_____
O Single O Married O Divorced O Widowed

4 How Did You Hear About Us?

_____

5 Who is Accompanying the Child Today?

Full Name_____
Relationship to Child_____
Do you have legal custody of the child(ren)? Y / N

6 Other Parent or Involved Party

Full Name_____
Relationship to Patient_____
Billing Address_____
City_____ State_____ Zip_____
Cell Phone (___)_____

7 Primary Dental Insurance

Insurance Co Name_____
Address_____
Phone (____)_____
Group#_____ Member ID_____
Policy Owner's Name_____
Policy Owner's SSN_____
Policy Owner's Date of Birth_____
Policy Owner's Employer_____

8 Secondary Dental Insurance

Insurance Co Name_____
Address_____
Phone (____)_____
Group#_____ Member ID_____
Policy Owner's Name_____
Policy Owner's SSN_____
Policy Owner's Date of Birth_____
Policy Owner's Employer_____

9 Emergency Contact (not living with you)

Name_____
Phone_____

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for standard and proper care. I authorize the release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits and to other health care professionals. I hereby authorize payment of insurance benefits directly to Big Blue Pediatric Dentistry, otherwise payable to me. I understand that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental insurance. I attest to the accuracy on this page.

Signature _____ Date_____

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Medical/Health History

Patients Name_____ Birthdate_____ Today's Date_____

Dental History

Is this your child's first visit to the dentist? ☐Yes ☐No
If No, when was their last visit_____
Previous Dentist Name _____
Were any x-rays taken at the previous visit? ☐Yes ☐No
Have any cavities been noted in the past? ☐Yes ☐No
Has your child had any problem with dental treatment?
If so please explain _____
_____
Have they ever received local anesthetic? ☐Yes ☐No
Has your child ever had sealants placed? ☐Yes ☐No
Have there been any injuries to your child's teeth or face (falls, blows, chips etc.)? Please explain_____
_____
Does your child receive fluoride by any of the following?
☐Water ☐Toothpaste ☐Drops ☐Tablets ☐Rinse or Gel

How often does your child brush_____
How often does your child floss_____
Does your child have any of the following habits?
☐Nursing/Bottle at night ☐Lip Sucking/Biting
☐Pacifier ☐Grinding
☐Thumb/Finger sucking ☐Snoring
☐Nail Biting ☐Mouth Breathing

Are there any other considerations we should know about when treating your child? (anti-fluoride, non-vacc, x-ray concerns etc.)_____
_____
Why did you bring your child to the dentist? _____
_____

Medical History

Child's Pediatrician_____
Pediatrician's Phone_____
Is your child seeing any medical specialist? ☐Yes ☐No
If so, Name_____
Phone Number_____
Drugs/Medications your child is taking_____
_____
Please list any allergies (drugs, latex, food etc.)_____
_____
Has your child ever had surgery_____
_____
Please discuss any serious medical conditions_____
_____
_____

Has your child had any of the following conditions?

- ☐ ADD/ADHD
- ☐ AIDS/HIV+
- ☐ Allergies
- ☐ Asthma
- ☐ Autism
- ☐ Blood Disorders
- ☐ Bone/Muscle Disorder
- ☐ Cancer
- ☐ Congenital Birth Defect
- ☐ Convulsions/Epilepsy
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Disabilities/Special Needs
- ☐ Eating Disorder
- ☐ Hearing/Visual Impairment
- ☐ Heart Disease/Murmur
- ☐ Hepatitis
- ☐ Hospital Stays
- ☐ Immune Disorder
- ☐ Kidney/Liver Conditions
- ☐ Rheumatic/Scarlet Fever
- ☐ Tuberculosis

Please Describe any conditions checked _____
_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. **I authorize the dental staff to perform the necessary dental services my child may need.**

Signature of parent _____ Date_____
Doctor Signature _____ Date_____

Big Blue
pediatric dentistry

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Pediatric Dentist
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APPOINTMENT POLICY

We strive to see all patients on time for their scheduled appointment. There are times when we are delayed in order to accommodate an injured child or emergency. We apologize in advance and promise you the same courtesy if your child is in need of emergency treatment.
Please give at least 48 hours' notice if a cancellation is unavoidable. If a cancelled or missed appointments occur without 48 hour notice, a $53.00 broken appointment fee for each appointment will be charged.
A parent or legal guardian must be present during all appointments. A form may be completed for someone other than a parent or legal guardian to be present.
The scheduled appointment is reserved specifically for your child. We prefer to schedule all restorative procedures in the morning for children 6 years and younger as they more prepared and do better than the afternoon. _____Initial

FINANCIAL POLICY

The guardian bringing the child is legally responsible for payment of all charges. We cannot split payments between two parents so please make payment arrangements in advance.
Payment is expected in full for each appointment at the time of service.
A deposit of $50 is required to schedule an appointment dental treatment which will be credited towards the treatment provided.
Types of payment accepted are cash, personal checks and major credit cards. There is a $50.00 fee for all returned checks.
Dental insurance Please be sure that you are familiar with your own insurance benefits. You are ultimately responsible for understanding your own benefits. PLEASE UNDERSTAND that we file insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles or pays its claims.
All outstanding balances must be paid in full within thirty (30) days whether insurance has paid or not, unless other arrangements have been made. If we have not received payment within thirty (30) days, further action may be taken. _____Initial

Parent/Guardian Signature_____ Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

*You may refuse to sign this acknowledgement

I, _____, have received a copy of this Office's Notice of Privacy Practices.

Signature _____ Date_____

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