JENSEN PEDIATRIC DENTISTRY
Regina Jensen, DDS, PA

Today's Date: _____/_____/_____

Who is accompanying your child today? _____ Relationship to child: _____

Do you have legal custody of this child? □ YES □ NO

Child's Information

Name: _____

□ Male □ Female Age: _____

Birthdate: ___/____/_____ SSN: _____-____-_____

Home address: _____

_____

Approximate date of your child's last visit to the dentist:

_____

Name of previous dentist: _____

_____

Primary Dental Insurance Information

Policy owner's name:_____

Relationship to child: _____

Policy owner's employer:_____

Insurance name: _____

Insurance phone number: _____

Insurance address: _____

_____

Subscriber ID (SSN) # _____

Group number:_____

Parent/Legal Guardian Information:

Parent #1: _____

□ Mother □ Stepmother □ Guardian

Date of birth: ___/____/_____ SSN: _____-____-_____

Cell Phone: _____

Email: _____

Occupation: _____

Employer: _____

Work Phone: _____

Parent #2: _____

□ Father □ Stepfather □ Guardian

Date of birth: ___/____/_____ SSN: _____-____-_____

Cell Phone: _____

Email: _____

Occupation: _____

Employer: _____

Work Phone: _____

CHILD'S HEALTH HISTORY

YES NO Is your child adopted?

YES NO Is your child currently taking any medication? If yes, please list: _____

YES NO Is your child allergic to any medications? If yes, please list: _____

YES NO Is your child allergic to latex products?

YES NO Is your child currently under the care of a physician? (other than routine well checks)

YES NO Have you ever been told your child needs premedication for a heart condition before dental treatment?

YES NO Are you child's immunizations up to date?

Has your child ***ever*** had any of the following?:

Y	N	Abnormal bleeding	Y	N	Cystic Fibrosis	Y	N	HIV/AIDS
Y	N	ADD	Y	N	Developmental delay	Y	N	Hospitalization or surgery
Y	N	ADHD	Y	N	Diabetes	Y	N	Kidney/bladder problems
Y	N	Anemia	Y	N	Disability/Special Needs	Y	N	Liver Problems
Y	N	Asthma or lung condition	Y	N	Ear Infections	Y	N	Mental delay
Y	N	Autism	Y	N	Emotional/behavioral disorder	Y	N	Pregnancy
Y	N	Brain Injury	Y	N	Eye problems	Y	N	Rheumatic/scarlet fever
Y	N	Cancer	Y	N	Hearing loss or impairment	Y	N	Seasonal Allergies
Y	N	Cerebral palsy	Y	N	Heart disease/defect	Y	N	Sickle Cell Anemia
Y	N	Cleft lip and/or palate	Y	N	Heart murmur	Y	N	Spina Bifida
Y	N	Congenital birth defect	Y	N	Hemophilia/any blood disorder	Y	N	Tuberculosis
Y	N	Convulsions or seizures	Y	N	Hepatitis	Y	N	Thyroid problems

Please explain any YES responses: _____

_____

CHILD'S DENTAL HISTORY

Reason for today's visit: _____ Is your child in pain: □ YES □ NO

Does/did your child suck: □ Thumb □ Finger □ Pacifier Age discontinued: _____

Is/was your child: □ Breast-fed □ Bottle-fed Age discontinued: _____

What is your water source? □ Public/City □ Private/Well □ Mostly Bottled □ Reverse Osmosis System

I □ *always* □ *sometimes* □ *never* supervise my child's brushing

Toothbrushing is done ____ times a day

Flossing is done □ *always* □ *sometimes* □ *never*

Has your child ever been seen by an orthodontist? □ YES □ NO Name: _____

SCREENING DURING COVID-19 ERA

Please take your's and your child(ren)'s temperature at home prior to your appointment and only come in if it is below 100.3 F. Please expect for your's and your child(ren)'s temperature to also be taken at their visit upon arrival.

Please fill out the following COVID-19 prescreening on the morning of your child's appointment and bring with you to the appointment. If you or your child has experienced any of the following symptoms, please notify our office prior to your appointment. We will discuss your health status, the dental treatment your child needs, and whether or not visiting our office will be safe for you, your child, our other patients, and our staff.

Child's Name: _____

Has your child or the guardian accompanying your child to the appointment had any of the following in the last 14 days:	Child	Guardian
Fever (greater than 100.3)?	□ YES □ NO	□ YES □ NO
Shortness of breath or other difficulties breathing?	□ YES □ NO	□ YES □ NO
Cough?	□ YES □ NO	□ YES □ NO
Any other flu-like symptoms, such as chills, muscle pain, headache, fatigue?	□ YES □ NO	□ YES □ NO
Experienced recent loss of taste or smell?	□ YES □ NO	□ YES □ NO
Sore throat?	□ YES □ NO	□ YES □ NO
Nausea, vomiting or diarrhea?	□ YES □ NO	□ YES □ NO
In contact with any confirmed or suspected COVID-19 positive patients?	□ YES □ NO	□ YES □ NO

Thank you for your continued trust in Jensen Pediatric Dentistry. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so. As with the transmission of any communicable disease like a cold or flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place.

Despite our careful attention to sterilization, disinfection, social distancing, and use of personal barriers, there is still a chance you could be exposed to an illness in our office, just as you might be in any public place. Due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dentist, dental team and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment? □ YES □ NO

Signature: _____ Date:_____

JENSEN PEDIATRIC DENTISTRY
X-RAY CONSENT

Radiographic or x-ray examinations provide your dentist with an important tool that shows the condition of your child's teeth, its roots, jaw placement and the overall composition of facial bones. X-rays allow the dentist to diagnose and treat conditions that cannot be detected during a clinical examination. Dental x-rays detect much more than cavities. For example, x-rays may be needed to survey erupting teeth or missing teeth, diagnose bone diseases, evaluate the results of an injury, or plan orthodontic treatment.

Do all patients have x-rays taken every six months?
No. Your child's radiographic schedule is based on the dentist's assessment. In most cases, new patients require a full mouth set of x-rays to evaluate oral health status, including any incipient lesions and for future comparison. Established patients may require x-rays every six months to monitor incipient lesions.

What kind of x-rays does the dentist usually take?
Typically, most patients have "periapical" or "bitewing" radiographs taken. Bitewing x-rays typically determine the presence of decay in between teeth, while periapical x-rays show root structure, bone levels, cysts, and abscesses.

My dentist has prescribed a "panoramic radiograph". What is that?
A panoramic radiograph allows the dentist to see the entire structure of your child's mouth in a single image. This x-ray reveals all of the upper and lower teeth and parts of the jaw. It will also show any abnormal growths, cysts and tumors. It is also used to evaluate for impacted or missing teeth.

Why does my child need both types of x-rays?
What is apparent through one type of x-ray often is not visible on another. The panoramic x-ray will give the dentist a general and comprehensive view of your child's entire mouth on a single film, which a periapical or bitewing x-ray cannot show.

Should I be concerned about exposure to radiation?
All healthcare providers are sensitive to patients' concern about exposure to radiation. Your dentist has been trained to prescribe radiographs when they are appropriate and to tailor radiographic schedules to each patient's individual needs. By using state-of-the-art technology your dentist knows which techniques, procedures and x-ray films can minimize your child's exposure to radiation.

Child's Name: _____ Date: _____

I **accep**t the recommended x-ray procedures:

Signature: _____

If you choose to wait on x-rays in our office it is with the understanding that it is in direct opposition to Dr. Jensen's recommendations. In some cases, she may ask you to seek services at an office that would agree to treat your child without radiographic examination.

I **decline** recommended x-rays procedures:

Signature: _____