Pediatric Dentistry
OF NEWBURGH

If someone referred you to our office, please provide their name here so we can thank them: _____

Names of other family members already being seen in our office: _____

Parent / Guardian

Last:_____ First: _____

DOB: _____ SS#: _____

Address: _____

Zip: _____

Home Phone: (_____) _____

Cell Phone: (_____)_____

Parent / Guardian

Last:_____ First: _____

DOB: _____ SS#: _____

Address: _____

Zip: _____

Home Phone: (_____) _____

Cell Phone: (_____)_____

Email Address: _____ (only used for appointment reminders)

Emergency Contact Number: _____ (if different from above)

Children

1. Last Name:_____ First:_____ MI:_____ Preferred:_____

Gender: _____DOB: _____SS#:_____ IN Medicaid #: _____ (if applicable)

Address / Phone (If Different from parent): _____

2. Last Name: _____ First:_____ MI:_____ Preferred:_____

Gender: _____DOB: _____SS#:_____ IN Medicaid #: _____ (if applicable)

Address / Phone (If Different from parent): _____

3. Last Name: _____ First:_____ MI:_____ Preferred:_____

Gender: _____DOB: _____SS#:_____ IN Medicaid #: _____ (if applicable)

Address / Phone (If Different from parent): _____

4. Last Name: _____ First:_____ MI:_____ Preferred:_____

Gender: _____DOB: _____SS#:_____ IN Medicaid #: _____ (if applicable)

Address / Phone (If Different from parent): _____

Insurance Information (if applicable) PRESENT INSURANCE CARD AT EVERY VISIT

Insurance Holder's Name:_____

DOB: _____SS#:_____

Address: _____City: _____ State:_____ Zip: _____
(If different than above)

Employer: _____Insurance Name: _____

Member ID#: _____Group Name or #:_____

DENTAL HISTORY and MEDICAL HISTORY

What is the reason this patient is here today? (Circle all those below that apply, or write in the information.)

Toothache Regular Checkup and Cleaning Orthodontic Problem Alignment of the Teeth Bite Problem

Referred for Treatment by Another Dentist Referred by a Physician for Examination Ulcer / Mouth Sore

Accident or Injury to Mouth/Teeth Mouth Pain of Unknown Cause Appearance of the Teeth

List name(s) of previous dentist(s) _____

What was the date of this patient's last visit to a dentist? _____

What was that visit for? _____

Is this patient's drinking water fluoridated? _____

Please list any prescription drugs this patient is taking, including the dosage and number of times per day:

_____

_____

_____

Please list any non-prescription drugs this patient is taking, including the dosage and number of times per day:

_____

_____

_____

List the dates and reasons of the times this patient has been hospitalized for any illnesses:

_____

_____

_____

List any medications that this patient is allergic to:

_____

_____

_____

List the dates and reasons of the times this patient has been operated on and/or has been put to sleep (anesthesia):

_____

_____

_____

Circle any of the following conditions that this patient has ever experienced in his/her lifetime:

Hyperactivity (ADHD or ADD)	Kidney Disease	Cancer / Malignancy	Premature Birth	Heart Disease or Malformation
Allergies	Kidney Infections	Venereal Disease	Fen-Phen or other Diet Drugs	Lung Disease or Trouble Breathing
Surgery or Hospitalization	Seizures / Convulsions	Herpes	Drug Dependency or Abuse	Bulimia or Anorexia
Serum Hepatitis	Asthma	Fever Blisters	Alcohol Dependency	Thumb or Finger Sucking Habits
Infectious Hepatitis	Croup or Bronchitis	Mental Retardation	Mood Affecting Medication	Nervous Disorders
AIDS	Anemia	Cerebral Palsy	Tranquilizers	*(For any of these circled, please write a brief summary below of the problem and how it was treated and resolved or its current status.*
HIV	Excessive Bleeding	Manic / Depressive (Bipolar)	Antidepressant Medication	
Liver Disease	Hemophilia	Depression	Heart Murmur	
Autism	Down Syndrome			

_____

_____

_____

Pediatric Dentistry
OF NEWBURGH

Thomas G. Ison, D.M.D.
8966 Ruffian Lane • Newburgh, IN 47630
812.490.8070

Patient: _____ **DOB:** _____

I, _____, as parent, legal guardian or authorized caregiver, understand that Dr. Ison will be performing the following procedure(s):

_____ Sealants _____ Fillings _____ Stainless Steel Crowns

_____ Extractions _____ Pulp therapy _____ Space maintainers

_____ Frenectomy

____Other: _____

I understand that the following medication(s) will be utilized for the dental treatment:

_____ Topical anesthetic _____ Local anesthetic _____ Nitrous oxide

_____ Valium _____ Other:_____

While these medications are routinely used during dental procedures, I understand that there can be undesired side effects, including but not limited to: nausea, lack of coordination, drowsiness, breathing difficulties, and possibly allergic reactions which could lead to shock or even death. The patient may experience numbness, swelling of lips or cheeks, bruising, discomfort, and/ or bleeding from dental procedures.

I understand that failing to treat dental conditions such as cavities, gum disease, tooth development or eruption issues, can result in progressing in severity of the condition. If dental conditions are untreated, the patient may experience pain or infection, and/or could require more extensive treatment to resolve the condition.

I have had the treatment plan explained to me to my satisfaction, understand the options presented, and give consent for Dr. Ison to provide dental care.

_____ _____

Name of parent/guardian (print) *Date signed*

_____

Signature of parent/guardian (print)

Pediatric Dentistry
OF NEWBURGH

THOMAS G. ISON, D.M.D.
8966 RUFFIAN LANE
NEWBURGH, IN 47630
812.490.8070

Patient Name: _____
Patient Date of Birth:_____
Address: _____
City:_____ **State**_____ **Zip**_____

I authorize my insurance company to pay directly to Pediatric Dentistry of Newburgh / Thomas G. Ison, DMD, LLC unless I pay in full at time of service.

I agree to pay all fees or my portion not covered by my dental insurance for the above-mentioned patient, at the time of service. I realize I am also responsible for full payment of fees not paid by insurance within 30 days of notification by this office. I also agree to be responsible for any fees required to collect payment for services including attorney and court costs, collection agency fees, pre-judgement and/or post-judgement interest at the current legal rate.

_____ _____
Name of parent/guardian (print) **Date signed**

_____
Signature of parent/guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below acknowledges that I have been provided a copy of Pediatric Dentistry of Newburgh "Notice of Privacy Practices", which has an effective date of 11/12/2019, and which describes how my health information may be used and disclosed. I Understand that PDON has the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact PDON at any time to request a current Notice of Privacy Practices.

_____ _____
Name of parent/guardian (print) **Date signed**

_____
Signature of parent/guardian