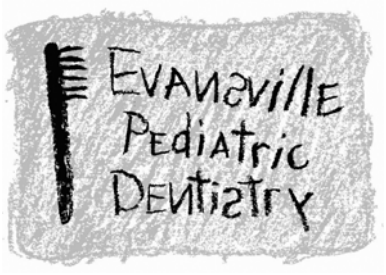

Jeffrey A. Hiester, D.D.S.

EAST
7200 E. Virginia Street
Evansville, IN 47715
(812) 479-8609

WEST
2345 W. Franklin Street #101
Evansville, IN 47712
(812) 401-6095

Personal Information

Patient's Name □ *Male* □ *Female*	*Preferred Name*	*Date of Birth*
Street Address	*City*	*State* *Zip*

Father's Name	*Social Security Number*	*Date of Birth*
Street Address (□ *Check if same as child)*	*City*	*State* *Zip*
Employer	*Email*	
Home Phone	*Business Phone*	*Cell Phone*
Mother's Name	*Social Security Number*	*Date of Birth*
Street Address (□ *Check if same as child)*	*City*	*State* *Zip*
Employer	*Email*	
Home Phone	*Business Phone*	*Cell Phone*

Insurance Information

Primary Dental Insurance is Held by □ Father □ Mother □ Other	*Dental Insurance Company*
Insurance Company Address	*City* *State* *Zip*
Employer	*Employee*
Policy Number	*Group Number*
Person Responsible for Account	
Whom may we thank for referring you to our office	

I, being the parent or guardian of the patient, do hereby authorize and request the performance of dental services for this patient. I certify that I have read and understand all information required on this form. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold the dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____ _____

Signature of Parent / Guardian Relationship Date

Have you (the parent/guardian) or the patient had any of the following diseases or problems? …….…. ☐ Yes ☐ No

- Active Tuberculosis
- Persistent cough greater than 3 week duration
- Cough that produces blood

If you answer YES to any of the three items above, please stop and return this form to the receptionist

Has the child had any history of, or conditions related to any of the following:

☐ ADD / ADHD	☐ Autism	☐ Growth Problems	☐ Jaundice	☐ SBE Pre-medication
☐ Allergy – Latex	☐ Bleeding Disorder	☐ Head Injuries	☐ Kidney	☐ Sickle Cell
☐ Allergy – Penicillin	☐ Cancer	☐ Heart	☐ Liver	☐ Sinus Problems
☐ Allergy – Sulfa	☐ Cerebral Palsy	☐ Heart Murmur	☐ Mental Disorder	☐ Stomach
☐ Allergy - Other	☐ Cleft Lip / Palate	☐ Hepatitis	☐ Nervous Disorder	☐ Tuberculosis
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Pregnancy	☐ Tumors
☐ Artificial Joints	☐ Downs Syndrome	☐ HIV+ / AIDS	☐ Respiratory Problems	☐ Ulcers
☐ Asthma	☐ Epilepsy / Seizures	☐ Hydrocephaly	☐ Rheumatic Fever	☐ Other Condition

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

	YES	NO
● Is the child taking any medications at this time? (if Yes, please list below) …….....	☐	☐
● Is the child allergic to any foods? ……	☐	☐
● Has the child ever had a serious illness or hospitalization? ……..…….……..	☐	☐
● Does the child have any learning and / or speech problems? ……..……..	☐	☐
● Is the child physically or emotionally impaired? ……..……..	☐	☐
● Has the child suffered any past injuries to the head, mouth, or teeth? ……..……..……..	☐	☐
● Does the child have any problems with eruption or shedding of teeth? ……...……..……..	☐	☐
● Does the child suck a finger, thumb, or pacifier? ……..……..……..	☐	☐
● How many times per day does the child brush their teeth? _____ Who does the majority of the brushing? _____		
● Does the child use fluoride toothpaste ……..……..	☐	☐
● Is this the child's first visit to the dentist? ……..……..……..	☐	☐

● What was the date of the last dental visit? …… _____ / _____ / _____

● What services were performed at the last dental visit?

☐ Examination ☐ Fillings ☐ Cleaning & Fluoride ☐ Extractions ☐ Uncooperative for treatment

● What does the child mostly drink?

☐ City Water ☐ Well Water ☐ Filtered / Bottled Water ☐ Juice ☐ Milk ☐ Soda

● Please explain past experiences that might effect the child's first visit to the dentist.

_____

_____

_____

Office Use Only

Medical Alerts: