Dr. Jane Silk, D.D.S.
Pediatric Dentistry
6200 SOM Center Road, Suite D-11
Solon, Ohio. 44139
Phone: (440) 248-1995

Child's Name:_____________________________________ Today's Date: ___________________
Date of Birth:_________________________ Age: __________ Male:______ Female:_______
Home Address: ____
____________________________________ Phone: ___________________________________

Mother's Information:
Name: ____
Birthdate: ___________________________ S.S. #: _____________________________________
Home Phone: ________________________ Cell Phone: _______________________________
Work Phone: _________________________ May we contact you at work? YES / NO
Employer:____
E-Mail:____

Father's Information:
Name:____
Birthdate : __________________________ S.S. #:_____________________________________
Home Phone:________________________ Cell Phone:_______________________________
Work Phone:________________________ May we contact you at work? YES / NO
Employer:____
E-Mail:____

Marital Status:
Married_______ Single_______
Widowed_______ Divorced_______
Partnered_______ Separated_______

Who is accompanying the patient today?____
Is your child adopted?___________________ Is your child in foster care?_________________

Whom may we thank for referring you to our office?___________________________________

PRIMARY DENTAL INSURANCE INFORMATION:

** Dr. Silk is not a network provider for any insurance company. Our office will be happy to submit your claim to your insurance company; however, if the insurance company does not cover 100% of our fees, you will be responsible for the remaining balance. We are not a state funded provider.

Subscriber:____

Subscriber Date of Birth:___________________ S.S. #:_________________________________

Dental Insurance Company:____

Phone Number:____

Insurance Company Address:____

Employer:____

Employer Address:____

Group Number:___________________________ Member I.D.:__________________________

SECONDARY DENTAL INSURANCE INFORMATION:

Subscriber:____

Subscriber Date of Birth:___________________ S.S. #:_________________________________

Dental Insurance Company:____

Phone Number:____

Insurance Company Address:____

Employer:____

Employer Address:____

Group Number:___________________________ Member I.D.:__________________________

Dental & Medical History:

Why did you bring the patient to the dentist today?

____

____

Does the child require antibiotics before dental treatment? YES / NO
Has the child ever had a serious/difficult problem associated with previous dental work? YES / NO
Is the child's water fluoridated? YES / NO
Is the child taking fluoride supplements? YES / NO
Is the child currently under the care of a physician? YES / NO
Child's Physician:____
Phone #:_______________________________ Date of last visit:__________________________
Please describe the child's current physical health: Good / Fair / Poor
Were there any concerns/problems at birth? ____
Was the child a full term baby? YES / NO If not, How many weeks? ______________________
Please list all prescription, over the counter, or supplement drugs that the child is currently taking. Also, list the reason for taking the medication.

____

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____

Please list all drugs/things that the child is allergic to.

____

____

____

____

Has the child experienced the following medical problems?
YES / NO Abnormal bleeding/Hemophilia
YES / NO ADD/ADHD
YES / NO AIDS/HIV+
YES / NO Anemia
YES / NO Any hospital stays/ operations? Please explain:

____

____

YES / NO Artificial bones/joints/valves
YES / NO Asthma
YES / NO Cancer
YES / NO Chicken Pox
YES / NO Congenital Heart Defect
YES / NO Convulsions
YES / NO Diabetes
YES / NO Epilepsy

YES / NO Hepatitis
YES / NO Hives/Skin rash
YES / NO Kidney Problems
YES / NO Liver Problems
YES / NO Low/High Blood Pressure
YES / NO Lupus
YES / NO Measles
YES / NO Mitral Valve Prolapse

YES / NO Exposed to HIV, but Neg.
YES / NO Handicaps/Disabilities
YES / NO Hearing Impairment
YES / NO Heart Murmur
YES / NO Sickle Cell Disease
YES / NO Tuberculosis (TB)
YES / NO Mononucleosis
YES / NO Prosthetics
YES / NO Rheumatic Fever
YES / NO Scarlet Fever
YES / NO Stroke

Are the child's immunizations current? YES / NO

Is there anything you would like to discuss with Dr. Silk in private? YES / NO

Does/did the child experience any of the following?
YES / NO Breast Fed
YES / NO Chewing on objects
YES / NO Clenching/ Grinding teeth
YES / NO Lip Sucking/ Biting
YES / NO Mouth Breather
YES / NO Nail Biting
YES / NO Nursing Bottle Habits
YES / NO Speech Concerns
YES / NO Thumb/Finger Sucking
YES / NO Tongue/Cheek Biting
YES / NO Tongue Thrust
YES / NO Used Pacifier

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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/Guardian Date