Dr. Susie S. Hayden
Dr. Renee T. Mikulec
Dr. Kara Whittington

Dr. Courtney L. Alexander
Dr. Royana Lin

New Patient Packet

Patient Information

Patient Name: _____ Today's Date: _____
Last First MI

Preferred Name: _____ Gender: _____ Birth Date: _____

Primary Number: _____(C/W/H) Secondary Number: _____ (C/W/H)

Address: _____
Street Apartment Number

_____
City State Zip Code

Best Email Address to Confirm Appointments: _____

Does your child have any siblings we already treat? ☐Yes ☐No _____

Where does your child go to school or day care? _____ Phone Number_____

Referral Information

How did you find out about our office? ☐Referred by another physician or dentist ☐Referred by a friend ☐Phonebook

☐Another child in your family ☐Other_____

Who can we thank for referring you to our office? Name: _____ Phone Number: _____

Patient Dental History

What is the reason for your child's dental visit today? _____

Is this your child's first visit to the dentist? ☐Yes ☐No If no, when was the last visit? _____

Previous Dentist's Name: _____ Did they take x-rays at their last visit? ☐Yes ☐No

Have there been any injuries to the teeth, face, or mouth? If yes, please explain _____

Does your child have any major dental problems? ☐Yes ☐No Is your child taking fluoride supplements? □Yes □No

Is your child's water fluoridated? ☐Yes ☐No Does a parent assist with brushing/flossing your child's teeth □Yes □No

Does your child Floss his/her teeth daily? ☐Yes ☐No Does your child brush his/her teeth daily? □Yes □No

Do you think your child will react well to dental treatment? ☐Yes ☐No Explain_____

Has your child ever had a serious or difficult problem associated with previous dental work? _____

Does your child have any of the following habits? List all that apply. _____

Lip Sucking/Biting, Pacifier Habit, Nail Biting, Thumb/Finger Habits, Teeth Grinding, & Nursing/Bottle Habits.

Patient Health History

Name of child's Physician: _____ Phone Number: _____ Date of last physical exam: _____

☐Yes ☐No Is your child currently under the care of a physician? If so, why? _____

☐Yes ☐No Has your child ever been hospitalized? Emergency room? _____

☐Yes ☐No Has your child had any surgeries or operations? _____

☐Yes ☐No Is your child taking any medications? (Please give the name of medication, dose, and reason)

_____

☐Yes ☐No Does your child have any allergies to Medications, Foods, and/or Latex? _____

Dr. Susie S. Hayden
Dr. Renee T. Mikulec
Dr. Kara Whittington

Dr. Courtney L. Alexander
Dr. Royana Lin

Asthma Related Questions

If your child has asthma, please read the following questions carefully and answer them with as much information as you can provide. Asthma can effect dental treatment for children in many ways and we need as many details as possible.

Does your child have asthma? **YES/NO** When was asthma diagnosed? _____

When was the last asthma attack? _____ Do you consider asthma controlled? **YES/NO**

When was the last medical evaluation for asthma? _____ Does your child carry an inhaler? **YES/NO**

Has your child ever been hospitalized due to asthma? **YES/NO** What causes the asthma attacks? _____

When was the last time the inhaler replaced? _____

Does your child take any medications for asthma? **YES/NO** _____

Has your child had an attack occur in a dental office? **YES/NO** How often do you replace the inhaler? _____

Has your child ever been diagnosed with the following: (Please check all that apply and explain any issues on the line provided below.)

☐No known health concerns
☐ ADHD/ADD/Hyperactivity
☐ Acid Reflux/GERD
☐ **Allergies-** ☐ **Latex**
☐ **Seasonal-**_____
☐ **Food-** _____
☐ **Medication-**_____
☐ **Other-**_____
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Artificial Joints/Stent
☐ **Asthma**
☐ Autism/Aspergers
☐ Birth Defects
☐ Blood Disease
☐ Blood Transfusions
☐ **Cancer-** **Treating Physician:** _____
Phone Number: _____
☐ Celiac Disease
☐Cerebral Palsy
☐ Cleft Lip/Palate
☐ Cystic Fibrosis
☐ Depression
☐ Developmental Delay
☐ Diabetes
☐ Dizziness
☐ Epilepsy/Seizures
☐Eczema
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Hearing Disorder
☐ Hearing Problems
☐ **Heart Disease**
☐ **Heart Murmur-** ☐ **Innocent**
☐ **Requires Pre-med**
Childs Weight_____ **lbs.**
Treating Specialist: _____
Phone Number: _____
☐ Hepatitis- Type_____
☐ High Blood Pressure
☐ High Fevers
☐ HIV/AIDS
☐Hydrocephalitis
☐ Immunodeficiency
☐ Jaundice
☐ Kidney Disease
☐ Learning Disabled
☐ Liver Disease
☐ Mental Disorders
☐MRSA
☐ Nervous Disorders
☐ Pacemaker
☐ Physically Challenged
☐ Pregnancy- Due Date: _____
☐ Radiation Treatments
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Sensory Disorder
☐ Sinus Problems
☐ Speech Disorder
☐ Stomach Problems
☐ Stroke
☐Thyroid Condition
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Other: _____

Dr. Susie S. Hayden
Dr. Renee T. Mikulec
Dr. Kara Whittington

Dr. Courtney L. Alexander
Dr. Royana Lin

Family Information

Mother's Information (Circle One): Mother Step-Mother Guardian
(Circle One): Married Divorced Single Other: _____

Name_____
Title Last First MI

Birth Date: _____ Social Security Number: _____

Occupation: _____

Primary Number: _____ (H/W/C) Secondary Number: _____ (H/W/C)

Address: _____
Street Apartment Number

_____
City State Zip Code

Father's Information (Circle One): Father Step-Father Guardian
(Circle One): Married Divorced Single Other: _____

Name_____
Title Last First MI

Birth Date: _____ Social Security Number: _____

Occupation: _____

Primary Number: _____ (H/W/C) Secondary Number: _____ (H/W/C)

Address: _____
Street Apartment Number

_____
City State Zip Code

Person Responsible for Account

Name_____ Relationship to Child _____
Title Last First MI
(Fill out only if Information is different from above)

Birth Date: _____ Social Security Number: _____

Primary Number: _____ (H/W/C) Secondary Number: _____ (H/W/C)

Address: _____
Street Apartment Number

_____
City State Zip Code

Dr. Susie S. Hayden
Dr. Renee T. Mikulec
Dr. Kara Whittington

Dr. Courtney L. Alexander
Dr. Royana Lin

Primary Dental Insurance Information

Please remember we use this information to submit claims on your behalf. We are not responsible for knowing your insurance plans frequencies and limitations. Our doctors will recommend treatment that is necessary for your child based on their needs, not your insurances frequencies and limitations.

Dental Insurance Company Name: _____

Name of Insurance Policy Holder: _____
Title Last First MI

Relationship to patient: _____ Insurance Phone Number: _____

Insurance Address: _____

Employer Name or Insurance Group Name: _____

Insurance Group Number: _____ Policy Holder's ID Number: _____

I am aware my insurance plan is _____ (Please write In Network or Out of Network)

Please be aware if your insurance is considered out of network you are responsible for any differences between our fees and your insurance fees. Please speak with the front desk if you have any questions before your appointment is started.

Secondary Dental Insurance Information

Please remember that we do not accept secondary insurance as a form of payment. We are happy to print out a claim for you to submit yourself, or we can submit the claim on your behalf for a $15 fee per claim. For all secondary insurance claims we assign the benefits to you so that you receive all the reimbursement from the secondary insurance company.

Dental Insurance Company Name: _____

Name of Insurance Policy Holder: _____
Title Last First MI

Relationship to patient: _____ Insurance Phone Number: _____

Insurance Address: _____

Employer Name or Insurance Group Name: _____

Insurance Group Number: _____ Policy Holder's ID Number: _____

I am aware my insurance plan is _____ (Please write In Network or Out of Network)

Please be aware if your insurance is considered out of network you are responsible for any differences between our fees and your insurance fees. Please speak with the front desk if you have any questions before your appointment is started.

Dr. Susie S. Hayden
Dr. Renee T. Mikulec
Dr. Kara Whittington

Dr. Courtney L. Alexander
Dr. Royana Lin

Authorization for Appointments

Please be aware that for any appointment in our office we must have authorization for anyone other than a parent or legal guardian to bring the child.

For future appointments I hereby authorize the following individuals to bring my child for dental treatment in my absence. They are authorized to sign any necessary documents. This person is authorized to be updated on all dental and medical information regarding my child from this appointment date, and any date in the past. I also understand that I am giving this person the responsibility to relay any information from the appointment to myself, and/or spouse.

Name: Relationship:

1. _____ _____
2. _____ _____

****Please Initial the Following Statements****

_____ To the best of my knowledge, all of the preceding answers and information provided are true and correct. If the patient ever has any change in their health, I will inform the doctors at the next appointment without fail.

_____ As the parent or legal guardian of my child, I hereby authorize any doctor associated with Stone Oak Pediatric Dentistry and their designated representative to treat my child according to reasonable dental practices and standards.

_____I herby authorize Stone Oak Pediatric Dentistry to file claims and release any necessary information to my insurance company. I also hereby authorize assignment of benefits from my insurance company to Stone Oak Pediatric Dentistry. I understand and take full responsibility for any service that is not covered or not paid for by my insurance and/or any service rendered by Stone Oak Pediatric Dentistry.

_____ **Date**: _____

Signature of Parent or Guardian

_____

Printed Name of Parent or Guardian