Ancheta Pediatric Dental LLC
Janel S. Ancheta-Carroll, D.M.D. ***Diplomate, American Board of Pediatric Dentistry***
98-1247 Kaahumanu St. #205 Aiea, HI 96701 (808) 487-1000

Patient Information

Patient Name: ____ **Today's Date:**____________
First MI Last
Name child would like to be called:_______________________________
Date of birth: __________/_______/_______ **Age:**_____Yr._____Mo. **Gender:** M F
Month (MM) Day (DD) Year (YYYY)
Child resides with:______________________________ Home Phone:_________________________
Home Address:____
Street City/State Zip Code
Name and ages of other children in family____
Child's School:____ Grade: ________________
Mother/ Guardian Name:____ Cell:________________
First MI Last
Mother's Employer____ Work Phone:_______________
Job Title_________________________ Marital status: ____ Married ____ Single ____ Separated____ Widowed

Father/ Guardian Name:____ Cell:________________
First MI Last
Father's Employer:____ Work Phone:_______________
Job Title_________________________ Marital status: ____ Married ____ Single ____ Separated____ Widowed
Who has legal custody of patient?____________________________
Person to contact in case of emergency:_________________________ Phone:____________________

Whom may we thank for referring you to our office?____
What is the reason for your child's dental visit?____

Insurance Information

Primary Insurance: Primary person responsible for payment:_____________________________________
Type of insurance:____________________________ Subscriber's name:___________________________
Subscriber's SS# : ____________________________ Subscriber's DOB:___________________________
Subscriber #: _________________________Relationship to patient: _______________________________
Secondary Insurance:
Type of insurance:____________________________ Subscriber's name:___________________________
Subscriber's SS# : ____________________________ Subscriber's DOB:___________________________
Subscriber #: _________________________Relationship to patient: _______________________________
Military Personnel Only: Rank: _____E4 & below _____E5 & above; Unit: ___________________________

Medical History

(Please Circle)

Yes No Is your child in good health? Name of child's Physician___________________________
Date of last physical exam___________________________
Yes No Is your child under the care of a physician now? If so, why? ___________________________
Yes No Did the birth mother take any medications during pregnancy? Problems during pregnancy or birth?
____
Yes No Has your child ever been hospitalized? If so, why?_________________________________
Yes No Has your child had any surgeries? If so, why and when? _________________________________
Yes No Is your child currently taking any **medications**, *including non-prescription*? Please list medications and reason:____
Yes No Does your child have any allergies? To which? _________________________________
Yes No Allergic to Penicillin or other Antibiotics? To which? ___________________________
Yes No Allergic to Latex? Please explain ____
Yes No Allergic to Anesthetic? Please explain ____________________________________

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Does your child have or ever had any of the following conditions?

Yes	No	Heart defect or heart murmur	Yes	No	Seizures/ Epilepsy
Yes	No	Congenital heart defect	Yes	No	Cerebral Palsy
Yes	No	Rheumatic heart disease	Yes	No	Diabetes
Yes	No	Anemia	Yes	No	Alcohol/ Drug Abuse
Yes	No	Abnormal bleeding	Yes	No	Handicap/ Disability
Yes	No	Hemophilia	Yes	No	Developmental Delay
Yes	No	HIV/AIDS	Yes	No	Attention Deficit Hyperactivity Disorder
Yes	No	Hepatitis/Jaundice/Liver Disease	Yes	No	Eating disorder
Yes	No	Gastric reflux/ GI disease	Yes	No	Nervousness/Panic disorder
Yes	No	Kidney disease	Yes	No	Cleft lip/ Cleft palate
Yes	No	Asthma/ Hay fever	Yes	No	Speech delay
Yes	No	Cancer/tumors	Yes	No	Hearing loss
Yes	No	Recurrent headaches	Yes	No	Chromosomal abnormalities

Please explain on any items marked "Yes": ____

Dental History

Yes No Has your child ever been to the dentist? Name of dentist and Date____________________________________

Yes No Has your child had an exam, cleaning, fluoride, or x-rays within the last 6 months?_______________________

Yes No Has your child experienced any unfavorable reaction from previous dental care?________________________

Who brushes your child's teeth? _ Child _ Child/parent _ Parent When are the teeth brushed?____________________

Yes No Are your child's teeth flossed? _ Daily _ Weekly _ Occasionally _ Never

Yes No Has your child ever injured his/her teeth or gums? Explain_______________________________________

Yes No Does your child have pain with chewing, yawning, or wide opening?__________________________________

Yes No Does your child suck a finger, thumb or pacifier? Or have any oral habits? _____________________________

Yes No Does your child grind his/her teeth? When?_______________________________

Was your child: ____ Breast fed ____ Bottle fed At what age was it stopped?______________

Does/Did your child sleep with a bottle? ____Yes ___No

What is fed from the bottle? __Formula __Milk __Water __ Juice ____Soda

Yes No Is your child on fluoride supplements? What type?____

Yes No Does your child use a fluoride toothpaste?

Consent for Dental Treatment

I request and authorize Dr. Ancheta-Carroll and staff to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Ancheta-Carroll to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Ancheta-Carroll and staff will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature of Parent: ____ Date:__________________

Reviewed Medical History: ___________________________________ Date: __________________

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