



Jeffrey A. Hiester, D.D.S.

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

Personal Information

Patient's Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Preferred Name	Date of Birth
Street Address	City	State	Zip

Father's Name	Social Security Number	Date of Birth
Street Address (<input type="checkbox"/> 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 (<input type="checkbox"/> Check if same as child)	City	State Zip
Employer	Email	
Home Phone	Business Phone	Cell Phone

Insurance Information

Primary Dental Insurance is Held by <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other	Dental Insurance Company
Insurance Company Address	City State Zip
* Employer	* Employee * Date of Birth
* Policy Number / Social Security 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

*** This information is that which we are required by the government to obtain from you to file insurance ***

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:

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Autism | <input type="checkbox"/> Growth Problems | <input type="checkbox"/> Jaundice | <input type="checkbox"/> SBE Pre-medication |
| <input type="checkbox"/> Allergy – Latex | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Kidney | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Allergy – Penicillin | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart | <input type="checkbox"/> Liver | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Allergy – Sulfa | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mental Disorder <input type="checkbox"/> | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Cleft Lip / Palate | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Downs Syndrome | <input type="checkbox"/> HIV+ / AIDS | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Hydrocephaly | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> 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) YES NO
- Is the child allergic to any foods? YES NO
- Has the child ever had a serious illness or hospitalization? YES NO
- Does the child have any learning and / or speech problems? YES NO
- Is the child physically or emotionally impaired? YES NO
- Has the child suffered any past injuries to the head, mouth, or teeth? YES NO
- Does the child have any problems with eruption or shedding of teeth? YES NO
- Does the child suck a finger, thumb, or pacifier? YES NO
- How many times per day does the child brush their teeth? _____ Who does the majority of the brushing? _____
- Does the child use fluoride toothpaste YES NO
- Is this the child's first visit to the dentist? YES NO
- What was the date of the last dental visit? _____ / _____ / _____
- What services were performed at the last dental visit?

<input type="checkbox"/> Examination	<input type="checkbox"/> Fillings	<input type="checkbox"/> Cleaning & Fluoride	<input type="checkbox"/> Extractions	<input type="checkbox"/> Uncooperative for treatment
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- What does the child mostly drink?

<input type="checkbox"/> City Water	<input type="checkbox"/> Well Water	<input type="checkbox"/> Filtered / Bottled Water	<input type="checkbox"/> Juice	<input type="checkbox"/> Milk	<input type="checkbox"/> Soda
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- Please explain past experiences that might effect the child's first visit to the dentist.

Office Use Only

<i>Medical Alerts:</i>

