3306 East Spring Street
Seattle, WA 98122

MADRONA FAMILY DENTAL
LOREN A. TARR, DDS, PLLC

(206) 324-5400
fax (206) 860-4073
info@madronafamilydental.com

Thank you for trusting your child with our office. In order to serve he or she properly, please answer all questions on BOTH sides, so that we may diagnose their oral health as accurately as possible. All information will be kept strictly confidential.

CHILD'S NAME____PREFERRED NAME ____________________________

❑ Male ❑ Female Birthdate_______/_______/_______ Age__________Home Phone No. (______)____________________
❑transgender ❑ non-binary Preferred pronouns: ❑she,her,hers ❑he,him,his ❑they,them,theirs

Father's Name______________________________ SSN_______/_______/ _______ Birthdate________/_______/ ________
Mailing Address______________________________ City_______________________ State____ ZipCode ________________
Home Phone No. (______) _____________ Work Phone No. (______) _____________Cell Phone No. (______)____________
Email____ **Best number to contact you?** ❑ Home ❑ Cell ❑ Work
Father's Occupation______________________________________Employer____

❑ *Married* ❑ *Single* ❑*Partnered* ❑ *Separated/divorced* ❑*Widowed*

Mother's Name______________________________ SSN_______/_______/ _______Birthdate________/_______/ ________
Mailing Address______________________________ City_______________________State____ ZipCode ________________
Home Phone No. (______) _____________ Work Phone No. (______) _____________Cell Phone No. (______)____________
Email____ **Best number to contact you?** ❑ Home ❑ Cell ❑ Work
Mother's Occupation______________________________________Employer____

❑ *Married* ❑ *Single* ❑ *Divorced* ❑ *Separated* ❑ *Widowed*

With whom does this child reside? ____

Payment Is Expected At Time Of Each Visit

Please Check Method of Payment

❑ Cash ❑ Check ❑ Bankcard

Person responsible for this child's account:______________________________________Phone No. (______) _______________

WHOM MAY WE THANK FOR REFERRING YOU?____

Primary Dental Insurance

Employee ____
Relationship to Patient ________________________________
Employer ____
Insurance Co.______________________Group#___________
Insurance Phone No. ________________________________
Employee's SSN ____________________________________
Subscriber D.O.B. __________________________________

Secondary Dental Insurance

Employee ____
Relationship to Patient ________________________________
Employer ____
Insurance Co.______________________Group#___________
Insurance Phone No. ________________________________
Employee's SSN ____________________________________
Subscriber D.O.B. __________________________________

I have been given and understand Madrona Family Dental HIPPA Notices of Privacy Act.

Signature____Date ____________________________

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(Turn Page Over)

Dental History

Is this your child's first dental visit? ❑ Yes ❑ No
Date of last dental visit ______________________
Previous Dentist's Name and Location ______________________
____
Has your child ever had a bad dental experience? ❑ Yes ❑ No
Does your child feel nervous about having dental treatment? ❑ Yes ❑ No

Have there been any injuries to your child's teeth or jaws? Falls/Blows/Chips/etc.? ❑ Yes ❑ No
Does your child take antibiotics for a health condition before each dental visit? ❑ Yes ❑ No
Does your child receive fluoride in vitamins, tablets or water? ❑ Yes ❑ No
Has your child been seen by an orthodontist? ❑ Yes ❑ No

Health History

Is your child having any pain or discomfort at this time? ❑ Yes ❑ No
Has your child been hospitalized or seen a Medical Doctor in the past 2 years? ❑ Yes ❑ No
If so, for what condition? ______________________
____
Does your child have a personal Physician? ❑ Yes ❑ No
Physician's Name: ______________________
Date of last visit: ______________________
Reason for visit: ______________________

Is your child currently taking any prescriptions, over the counter drugs or herbal supplements? ❑ Yes ❑ No
If so, please list and include the reason for taking:
____
____
____
Please list any serious medical condition(s) that your child currently has or has had in the past: ______________________
____
____
____

Please Check any of the following which your child has now or has had in the past.

- ❑ **No medical conditions**
- ❑ Angina Pectoris (Chest Pain)
- ❑ Heart Disease/Attack/Stroke
- ❑ Heart Failure
- ❑ High/Low Blood Pressure
- ❑ Congenital Heart Defect
- ❑ Heart murmur/Rheumatic Fever
- ❑ Heart Surgery
- ❑ Heart Pacemaker
- ❑ Artificial Heart Valve
- ❑ Diabetes, Type I ❑ II ❑
- ❑ Blood Transfusion/Anemia
- ❑ Sickle Cell Disease
- ❑ Bruise Easily
- ❑ Hemophilia/Blood Disorder
- ❑ Liver Disease/Yellow Jaundice
- ❑ Kidney Failure/Dysfunction
- ❑ Thyroid Disease/Condition
- ❑ Ulcers
- ❑ Glaucoma
- ❑ Cosmetic surgery________
- ❑ Chemotherapy for Cancer X-ray
- ❑ Treatment for Cancer
- ❑ Tuberculoses (TB)
- ❑ Rheumatism/Lupus
- ❑ Cortisone therapy/Steroids
- ❑ Sexually transmitted infection
- ❑ A.I.D.S./H.I.V.
- ❑ Hepatitis: A, B, C
- ❑ Frequent headaches
- ❑ Artificial Joints (Hip, Knee, etc.)
- ❑ Canker Sores/Cold Sores
- ❑ Fainting/Dizzy Spells
- ❑ Epilepsy/Seizures
- ❑ Hay Fever/Sinus Trouble
- ❑ Allergies/Hives
- ❑ Shingles
- ❑ Anxiety Disorder
- ❑ Psychiatric Treatment
- ❑ Drug/Alcohol Addiction
- ❑ Emphysema/Asthma
- ❑ Depressed Immune System
- ❑ Organ Transplant
- ❑ Osteoporosis
- ❑ Other____________

Is your child allergic to or have they reacted adversely to any of the following?
Please check any that apply.

❑ Aspirin ❑ Demerol ❑ Valium ❑ Nitrous Oxide ❑ Erythromycin ❑ Other Antibiotics ❑ Metals/Jewelry
❑ Codeine ❑ Percodan ❑ Sulfa ❑ Penicillin ❑ Tetracycline ❑ Latex ❑ Local Anesthetic

*List any other allergies here:*______________________

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? (Outside of child's home)

Name______________________**Home Phone No.**(____)__________**Work Phone No.** (____)__________

Relationship to Patient______________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover.

Parent/Guardian Signature ______________________**Date**__________

Doctor Signature______________________**Date**__________

Update Record

Date	Initial
______	______
______	______
______	______

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