Lindsey Todorovich, DDS
Board Certified Pediatric Dentist

Ryan Todorovich, DDS
General Dentist

401 South Alabama St., Suite #3A • Butte, MT 59701
t: 406.723.KIDS (5437) f: 406.723.1205
info@buttepediatricdentistry.com
www.buttepediatricdentistry.com

pediatric dentistry

CHILD'S FULL NAME _____ Preferred Name _____

❑ Male ❑ Female Birthdate _____ Age _____

Number of children in family _____

Relationship to child: _____

PARENT 1 NAME _____ Birthdate ___/___/___ Social Security No. ___-___-___

Mailing Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Parent 1 Occupation _____ Employer _____ Work Phone _____

Cell Phone _____ Best Contact# _____ Email _____

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Relationship to child: _____

PARENT 2 NAME _____ Birthdate ___/___/___ Social Security No. ___-___-___

Mailing Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Parent 2 Occupation _____ Employer _____ Work Phone _____

Cell Phone _____ Best Contact# _____ Email _____

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

With whom does this child reside? _____

Would you prefer text message reminders? ❑ Yes ❑ No

If yes, what phone number: ❑ Parent 1 Cell ❑ Parent 2 Cell ❑ ***Other*** _____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Employee _____	Employee _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____
Insurance Co. _____ Group # _____	Insurance Co. _____ Group # _____
Insured Birthdate ___/___/___	Insured Birthdate ___/___/___
Employee's S.S. No. ___-___-___	Employee's S.S. No. ___-___-___

❑ No dental insurance

Person financially responsible for child's account: _____

* * * * * *

IN CASE OF EMERGENCY, OTHER THAN THOSE LISTED ABOVE WHOM MAY WE CONTACT?

Name _____ Home Phone _____ Work Phone _____

Relationship to Patient _____

Please answer all questions, so that we may diagnose your child's oral health as accurately as possible. All information will be kept strictly confidential. *Thank You*.

MEDICAL HISTORY

Is your child presently under the care of a physician? ..... ❑ Yes ❑ No
If so, for what condition? _____

Child's Physician _____

Date of last physical exam _____ Findings _____

Former Dentist _____

Is your child:

In good health? ..... ❑ Yes ❑ No

Sensitive or allergic to any medications, foods or latex? ..... ❑ Yes ❑ No
If yes, please list: _____

Taking any medications? ..... ❑ Yes ❑ No
If yes, please list: _____

Has your child ever had any surgeries? ..... ❑ Yes ❑ No
If yes, please list: _____

Does your child have any history of the following conditions (please circle):

ADD/ADHD
Adenoid/Tonsil Problems
Anemia
Asthma
Autism
Bleeding Problem
Blood Disorder
Blood Transfusion
Cancer
Cerebral Palsy
Cystic Fibrosis
Development Delay
Diabetes
Eczema/Skin Problems
Excessive Gagging
Fainting or Dizziness
GERD/Acid Reflux
Hearing Difficulty
Heart Murmur
Heart Problem
High Blood Pressure
HIV/AIDS
Hydrocephaly/Shunt
Hyper/Hypoglycemia
Impaired Vision
Intellectual Disability
Kidney Disease
Learning Problems/Delays
Liver Disease
Mononucleosis
Motor or Muscle Disorder
MRSA
Neglect/Abuse
Premature Birth
Psychiatric Problem
Seizure or Epilepsy
Sexually Transmitted Disease
Sickle Cell Disease
Sleep Apnea/Snoring
Speech Delay
Thyroid Problem
Tuberculosis (TB)

Does your child have any other Problems, Conditions or Special Needs?

_____

Is your child taking fluoride pills or drops? ..... ❑ Yes ❑ No

Has your child ever had an orthodontic evaluation or treatment (braces)? ..... ❑ Yes ❑ No

Name of Orthodontist _____

Is there any other information which will assist us in providing the best possible care for your child?

Please state here _____

How did you hear about us? _____

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 strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Drs. Ryan & Lindsey Todorovich and/or dental staff to perform the necessary dental services my child may need. This may include exams, radiographs, cleanings, topical fluoride treatment, restorative dentistry, oral surgery or limited orthodontics. In order to perform such treatment, our team may recommend the use of local anesthesia (numbing) and/or nitrous oxide (laughing gas).

Parent/Guardian Signature _____ Date ____/____/____

Dentist Signature _____