Welcome to

Madison Pediatric Dental and Orthodontics
Producing Great Smiles!
Dr. Douglas Wilson • Dr. Thomas Wenham • Dr. Grace Wenham
100 River Place, Suite 110 Madison, WI 53716
(608) 222-6160 Office (608) 222-6248 Fax

www.madisonpediatricdental.com

Date _____

Tell us about your child:

Child's Name _____ Nickname _____ Child's gender M F
Last First
Child's Date of Birth ___/___/___ Child's Age _____ Child's Home phone# _____

Child's Home Address _____
City State Zip

Whom may we thank for referring your child? _____
Other family members seen by us _____
Who is accompanying the child today? Name: _____ Relationship _____

Parent Information:

Name _____
Mother Father Guardian Foster Parent

Date of Birth ___/___/___ SS# _____
Home
Address _____
City State Zip
Home # (___) _____
Cellular Phone # (___) _____

Employer _____
Work # (___) _____ Ext. _____

Name _____
Mother Father Guardian Foster Parent

Date of Birth ___/___/___ SS# _____
Home
Address _____
City State Zip
Home # (___) _____
Cellular Phone # (___) _____
Email _____
Employer _____
Work # (___) _____ Ext. _____

Dental History:

Is this your child's first visit to the dentist? Y N
If No, previous dentist name? _____
Last visit date _____

Has your child ever had a problem associated with previous dental treatment? Y N
If yes, Please explain _____

Has your child had any injuries to their mouth, teeth or face? Y N
If yes, please explain _____

Does your child have any of the following oral habits?
- ☐ Lip sucking / Biting
- ☐ Nail Biting
- ☐ Currently breast feeding
- ☐ Currently using a bottle
- ☐ Thumb / Finger sucking

Do you assist your child with brushing teeth? Y N
How often? _____ Per day

Is dental floss used? Y N
How Often? _____ per day

Does your child take fluoride supplement? Y N
If Yes, what type? _____

Have missing teeth been replaced? Y N

Orthodontic appliances worn now or ever? Y N

Any unusual speech habits? Y N

_____

Please list another other dental concerns you may have: _____

Medical History:
Has your child ever been diagnosed as having any of the following conditions? Check all that apply

Y	N	
☐	☐	ADHD
☐	☐	AIDS/HIV+
☐	☐	Anemia
☐	☐	Asthma Triggered by:_____
☐	☐	Autism
☐	☐	Cancer Type:_____
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
	☐	Epilepsy/Convulsions:
☐		Seizures? Last date of seizure_____
☐	☐	Hearing impairment
☐	☐	Heart murmur
☐	☐	Hemophilia/Bleeding disorder
☐	☐	Hepatitis
☐	☐	Kidney/Liver condition
	☐	Special Needs
		Autism
		Disabilities/Handicaps
		Physical or psychological development delay
☐		_____
☐	☐	Tuberculosis
	☐	Pre-Med required for dental treatment
☐		Reason_____
	☐	Other_____
		_____

Allergies (drug ,environmental or latex):_____
_____
_____

Current medications:_____
_____
_____

Child's Physician_____
Clinic Name_____
Phone#(____)_____ Last Physical Exam?_____

Primary Insurance Information:
Insurance Co. Name_____
Address_____
_____
Insurance Co. Phone# (____)_____
Group#_____
Policy ID#_____
Policy Owner's Name_____
Relationship to child_____
Policy Owner's Birth Date____/____/____
Policy Owners Employer_____

Secondary Insurance Information:
Insurance Co. Name_____
Address_____
_____
Insurance Co. Phone# (____)_____
Group#_____
Policy ID#_____
Policy Owner's Name_____
Relationship to child_____
Policy Owner's Birth Date____/____/____
Policy Owners Employer_____

Third Insurance Information:
Insurance Co. Name_____
Address_____
_____
Insurance Co. Phone# (____)_____
Group#_____
Policy ID#_____
Policy Owner's Name_____
Relationship to child_____
Policy Owner's Birth Date____/____/____
Policy Owners Employer_____

Signature on file
I authorize the release of any information relating to treatment done on my child. I understand that and hereby authorize payment to Madison Pediatric Dental and Orthodontics from my group insurance benefits.

HIPPA
I understand & acknowledge the Notice of Privacy Practices. In addition my signature is written permission under Wisconsin law for the use of individuals dental records to carry out treatment & health information.

Financial Policy
Payment is due day of when non covered treatment is provided. We accept cash, personal checks & major credit cards. If needed we are willing to setup a payment arrangement. As a courtesy we will file a claim to your insurance. I understand and agree that I am ultimately responsible for the balance on this account.

The permission of the parent or legal guardian is necessary for dental treatment of a minor.
The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes. I authorize the dental staff to perform any and all necessary dental treatment my child needs.

_____
Parent/Legal Guardian Date