Alaska Premier Dental Group

Child Information

Patient Name:_____ Birthdate: _____
Last First M

Ĭ Male Ĭ Female Preferred name: _____ Home Phone:_____

Address:_____
Street Apt. or Unit #

_____
City ST Zip Code

Parent Information

Fatherôs Name_____ Social Security # _____Birthdate_____

Motherôs Name _____ Social Security # _____Birthdate_____

Father Employed by_____ Business Phone_____

Mother Employed by_____ Business Phone_____

Motherôs Cell_____ Fatherôs Cell_____

Closest relative not living with you: _____ Phone: _____

Health Information

Has your child ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A / B / C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Stomach Problems
- ☐ Sinus problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Thyroid
- ☐ STD
- ☐ Pregnant now?

Due Date:_____

Allergies:

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Peanuts
- ☐ Other: _____
- ☐ None of the Above

- Has your child ever had any complications following dental treatment? ☐ Yes Ĭ No
  If yes, please explain:_____
- Is your child now under the care of a physician? Ĭ Yes Ĭ No
  If yes, please explain:_____
- Name of Physician:_____Phone:_____
- Please list any current medications your child are taking:_____
- Is there any other medical or dental information you feel I should know about? Ĭ Yes Ĭ No
  If yes, please explain:_____
- What is the name of your last dentist? _____
  City_____ State_____ Phone _____
- How long has it been since your child has seen a dentist? _____
- What type of treatment was done at that time? _____
- Are any teeth sensitive to hot / cold/ sweets / chewing? If yes, please specify_____
- Does your child may have bad breath? ☐ Yes ☐ No

- Has your child ever complained of pain/tenderness in their jaw? If yes, please specify_____
- Thumb/Finger Sucking? ☐ Yes ☐ No Nail Biting? ☐ Yes ☐ No

  Lip Sucking/ Biting? ☐ Yes ☐ No Nursing Bottle Habits? ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION (PRIMARY)
Insuredôs Name DOB SS# /ID
Employer
Insurance Co.
Insurance Address
Phone #
Group #
Relationship to patient

DENTAL INSURANCE INFORMATION (Secondary)
Insuredôs Name DOB SS# /ID
Employer
Insurance Co.
Insurance Address
Phone #
Group #
Relationship to patient

To the best of my knowledge, the noted information is accurate and will only be used in regards to my childôs dental treatment, billing and processing of their dental insurance for benefits they are entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I authorize use of any information necessary to process my insurance. I authorize my insurance company(s) to issue the dental benefits of my plan directly to this office.

Informed Consent

Permission for Dental Exam and/or Treatment of a Minor

I, being the parent or guardian of_____ who is a minor, do hereby authorize and consent to any x-rays, examination, anesthetic, sedative, or dental treatment under the general, direct, or indirect supervision of all Doctors at APDG, or staff members as deemed necessary. I also understand that the use of anesthetic embodies a certain risk.

Parent or Guardian Signature_____ Date_____

Print Name_____ Relationship to patient_____

Doctor Signature_____ Date_____

For Office Use Only

Ĭ 6611 Debarr Rd, Suite 100
Anchorage, AK 99504
(907)337-1322

Ĭ 6611 Debarr Rd, Suite 200
Anchorage, AK 99504
(907)337-0404

Ĭ 865 N. Seward Meridian Pkwy, Suite 201
Wasilla, AK 99654
(907)373-5930