Step By Step Pediatric Dentistry
15614 Meridian Ave E Suite 400
Puyallup, WA 98375
stepbysteppediatricdentistry@gmail.com
Phone: 253-200-1700

About Your Child

Last Name:_____ First:_____ Middle:_____

Home Address:_____ Apt:_____ City:_____

State:_____ Zip:_____ Phone Number: (____)_____

Date of Birth:_____/_____/_____ Age:____ Sex:____ Birthplace:_____
MM DD YYYY M/F State (Country, if not US)

Parent / Guardian Information

Last Name:_____ First:_____ Middle:_____

Home Address:_____ Apt:_____ City:_____

State:_____ Zip:_____ Phone Number: (____)_____

Date of Birth:_____/_____/_____ Age:____ Sex:____ Email:_____
MM DD YYYY M/F

Social Security Number:____ -__-____ Driver's License Number:_____

Marital Status (circle): Single Married Domestic Partner Divorced/Widowed

Employer:_____ Occupation:_____

Employer Address:_____ City:_____ State:_____

Spouse/ Other Guardian Information

Last Name:_____ First:_____ Middle:_____

Home Address:_____ Apt:_____ City:_____

State:_____ Zip:_____ Phone Number: (____)_____

Date of Birth:_____/_____/_____ Age:____ Sex:____ Email:_____
MM DD YYYY M/F

Social Security Number:____ -__-____ Driver's License Number:_____

Marital Status (circle): Single Married Domestic Partner Divorced/Widowed

Employer:_____ Occupation:_____

Employer Address:_____ City:_____ State:_____

Emergency Contact

Last Name:_____First:_____Middle:_____

Relationship:_____ Phone Number: (____)_____

Primary Dental Insurance

Insurance Company Name:_____ Group:_____ Policy Number:_____

Address:_____ City:_____ State:_____ Zip:_____

Insured's Date of Birth:_____/_____/_____ Insured's Name:_____
MM DD YYYY

Insured's Social Security Number:___-__-_____ Relationship to Insured: _____

Do you have secondary insurance? (circle) Yes No Insurance Company Name:_____

Who Is Accompanying Child to the Appointment

Last Name:_____ First:_____ Middle:_____

Relationship:_____ Phone Number: (____) _____

Does the accompanying parent/guardian have legal custody of child (circle) Yes No

Parent/Guardian who accompanies the child is legally responsible for payment at time of service

How did you Hear About Step by Step Pediatric Dentistry?

☐ Referral ☐ Instagram/Facebook ☐ Website ☐ Recommendation from Friend

☐ Other (specify) _____

Dental History

Previous Dentist's Name:_____ Date of last dental visit: _____

Why did you bring your child to the dentist today? _____

	Circle Yes or No			Circle Yes or No	
Does/did your child breastfeed?	Yes	No	Does/did your child drink infant formula?	Yes	No
Does/did your child use a sippy cup?	Yes	No	Any teething problems?	Yes	No
Does/did your child sleep with a bottle?	Yes	No	Does your child take fluoride supplements?	Yes	No
Do you assist with brushing/flossing?	Yes	No	Is there a family history of cavities?	Yes	No

Has your child had problems with previous dental visits? Yes No If Yes , please explain_____

_____

When did you begin brushing child's teeth? _____ months

When did the child begin using toothpaste? _____ months

Any mouth habits? (circle any which apply) Thumb sucking Nail Biting Nursing bottle
Pacifier Mouth breathing Teeth Grinding

Does your child have a history of any of the following? If checked, describe

☐ Bad Breath _____ ☐ Mouth sores _____

☐ Bleeding Gums_____ ☐ Cavities _____

☐ Injury to teeth/mouth _____ ☐ Toothache_____

☐ Excessive gagging _____ ☐ Jaw joint problems _____

☐ Tooth Trauma _____ ☐ Sucking habit after 1 year _____

Health History

Physician's Name:_____ Location:_____

Date of last physical examination:_____/_____/_____

MM DD YYYY

Is your child being treated by a physician at this time? (circle) Yes No
Reason:_____

Is your child taking any medications or dietary supplements? (circle) Yes No
Dose, Frequency:_____

Has your child ever had a reaction to an anesthetic? (circle) Yes No
Describe:_____

Is your child up-to-date on immunizations against childhood diseases (circle) Yes No

Was your child born prematurely? (circle) Yes No

Has your Child had a history of the following conditions? If checked please describe

- ☐ Allergy to food _____
- ☐ Allergy to any drugs_____
- ☐ Allergy to Latex _____
- ☐ Developmental Disorder _____
- ☐ Family history of anesthesia problems _____
- ☐ Anemia _____
- ☐ Abnormal Bleeding_____
- ☐ Congenital Birth Defects _____
- ☐ Heart Condition_____
- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ Asthma_____
- ☐ Kidney or liver problems_____
- ☐ HIV + / AIDS_____
- ☐ ADD/ADHD _____
- ☐ Autism Spectrum Disorder_____
- ☐ Behavioral/ Emotional/ Psychiatric_____
- ☐ Skin problems/ Eczema_____
- ☐ History of Abuse_____
- ☐ Hormonal/ Thyroid Problems_____
- ☐ Impaired vision/ hearing/speech _____
- ☐ Gastric Reflux/ Stomach Problems_____
- ☐ Bladder/ Kidney Problems_____
- ☐ Cerebral Palsy_____
- ☐ Seizures_____
- ☐ Headaches/Migraines_____
- ☐ Tuberculosis_____
- ☐ None of the Above

Authorization for Treatment

I hereby authorize whatever services are deemed necessary during my appointment and agree to assume financial responsibility for all services provided. I understand this office will submit claims to the listed insurance company, but that I am ultimately responsible for this account.

Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In the event it should become necessary to place for collection any unpaid balance due for services rendered to this patient, I agree to pay collection fees, and should any legal action be filed, reasonable attorney fees, filing fees, and any other cost the court determines proper.

I understand that the information I have provided is correct and to the best of my knowledge. I also authorize the release of any medical information necessary to process my claim. It is my responsibility to inform this office of any changes in my child's medical status.

Last Name:_____ First:_____ Middle:_____

Signature:_____ Date: _____/ ____/ _____

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Media release

I give permission for Step By Step Pediatric Dentistry to use photographs or videos to be posted within our dental practice and/ or on our website, social media accounts, videos or slide show presentations, print ads and all other marketing or advertising efforts that promote our dental practice.

Last Name:_____ First:_____ Middle:_____

Signature:_____ Date: _____/ ____/ _____