Mertes Pediatric Dentistry, Inc.
5655 Hudson Drive Suite 300
Hudson OH 44236-4454
(330)655-5437
www.mertesdental.com
info@mertesdental.com

Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

How did you hear about our practice?

Primary Dental Insurance

Name of Insured: Last First MI

Insured's Birth Date: ID #. Group #.

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

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Secondary Dental Insurance

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____

City State Zip Code

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Medical & Dental Histroy

Your child's current primary care physician name and phone number:

Has your child ever been hospitalized?

◯ Yes ◯ No

If so, when and why?

Does your child have or has your child ever had any of the following conditions:

- ☐ Allegy - Egg
- ☐ Allergy - Food/Dye
- ☐ Allergy - Medication
- ☐ Allergy - Other
- ☐ Anemia
- ☐ Asperger's
- ☐ Asthma
- ☐ Autism
- ☐ Birth Defects
- ☐ Bleeding Problems
- ☐ Blind
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ Developmental delay
- ☐ Diabetes
- ☐ G-Tube Feeding
- ☐ Hearing Loss/Impair
- ☐ Heart Murmur/Defect
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Hyperactivity/ADHD
- ☐ Kidney Disease
- ☐ Learning Disability
- ☐ Liver Disease
- ☐ Mental Retardation
- ☐ Muscular Dystrophy
- ☐ Other
- ☐ Pregnant
- ☐ Pre-Med
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Skin disorders
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Spina Bifida
- ☐ STD(S)
- ☐ Syndrome (Specify)
- ☐ Tuberculosis

Please explain all checked responses and any other conditions your child may have:

Is your child currently taking any prescription or non-prescription medications?

◯ Yes ◯ No

If yes, please list all medications:

Does your child have any allergies to medications?

◯ Yes ◯ No

If yes, please list:

Does your child have any other allergies?

◯ Yes ◯ No

If, yes please list:

Is this your child's first visit to the the dentist?

◯ Yes ◯ No

If yes, name of previous dentist?

Reason for today's visit (check all that apply):

☐ Check-up ☐ Emergency ☐ Pain ☐ Treatment

How do you think your child will react to this dental visit?

☐ Cooperative ☐ Uncooperative ☐ Not Sure

To the best of my knowledge, all of the preceding information is true and correct. If my child has a change in their health, I will inform the office at their next dental appointment without fail.

Response Date: