Peter Lubisich IV D.M.D., M.S.
Josef W. Lubisich D.M.D., M.S.
Peter Lubisich III D.D.S.

Vancouver Pediatric Dentistry
Drs. Lubisich

Your child's legal name ______________________ Nickname __________
First MI Last

Sex: ❍ Male ❍ Female Birthday __________ Age __________

Who may we thank for referring you to our office? __________

Parent's (Guardian's) name __________

Address __________ City __________ State __________ Zip __________

Home # __________ Cell # __________ Email address __________

Please tell us the reason for your child's visit __________

Has your child been to the dentist before? ______Who? __________When? __________

The name of your family dentist (parent's dentist) __________

The name of your child's physician? __________

Have you or any members of your family been to our office before? __________

What are the names and ages of your child's siblings? __________

Please share with us your child's special interests? __________

Has your child had an unfavorable experience with previous medical or dental treatment? If so, please explain __________

Please share with us an suggestions that you feel would be helpful in caring for your child. __________

MEDICAL HISTORY

Has your child seen a physician in the past year? No ❍ Yes ❍ Why? __________

Has your child ever been hospitalized? No ❍ Yes ❍ Why? __________ When? __________

Has your child been diagnosed with any hearing, speech, emotional, or developmental conditions or syndromes?

Please explain __________

Is your child involved in any special education programs at school? If so, please explain __________

Does your child require pre-medication prior to dental treatment? __________

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Does or has your child drank from a bottle, used a pacifier, or sucked his/her fingers or thumb? ____________

Please list any medications your child is currently taking ____________

____

Does your child receive fluoride from any of the following? water ❍ tablets ❍ toothpaste ❍ rinse ❍

Describe any previous mouth injuries ____________

____

Please list any food, drug, or product allergies or sensitivities ____________

____

Please answer yes or no to each of the following:

yes	no		yes	no		yes	no	
❍	❍	Heart trouble	❍	❍	Bleeding problems	❍	❍	Anemia
❍	❍	Mitral Valve prolapse	❍	❍	Liver disease	❍	❍	Diabetes
❍	❍	Heart murmur	❍	❍	Kidney disease	❍	❍	Hepatitis
❍	❍	Tuberculosis	❍	❍	Rheumatic fever	❍	❍	Epilepsy
❍	❍	Infections	❍	❍	Intestinal problems	❍	❍	Asthma
❍	❍	Blood transfusions	❍	❍	Urinary problems	❍	❍	Surgeries

❍ Other ____________

Please explain if yes to any of the above ____________

____

Thank you for completing this form. This will help us to better understand and care for your child.

I hereby authorize that all necessary forms of dental treatment, medication, technique, therapy, and procedures be rendered for my child.

Signature ____________ Date ____________

Relationship to child ____________

FINANCIAL ARRANGEMENTS

❍ Cash / Check **(on day of visit)** ❍ Insurance ❍ Dual Insurance ❍ Public Assistance/ DSHS ❍ Visa / Mastercard