Welcome!

Robert A. Riebe, D.D.S. & Michael J. Riebe, D.D.S.
2155 Mentor Avenue Painesville Township, OH 44077 (440) 358-8000

Tell Us About Your Child

Child's Name: _____ Today's Date: _____

Child's Home Address: _____

_____

❑ Male ❑ Female Child's Home Phone #: (___) _____ Child's Birthday: ___/___/___ Child's Age: _____

Parent's Information

Mother: ❑ Mother ❑ Step-Mother ❑ Guardian

Birthdate: ___/___/___ Home Phone #: (___) _____ Work Phone #: (___) _____

Name: _____ Social Security #: _____

Address: _____

Employer: _____

Father: ❑ Father ❑ Step-Father ❑ Guardian

Birthdate: ___/___/___ Home Phone #: (___) _____ Work Phone #: (___) _____

Name: _____ Social Security #: _____

Address: _____

Employer: _____

Person Responsible for Account

Name: _____ Relationship: _____ Social Security #: _____

Billing Address: _____

Work Phone #: (___) _____ Home Phone #: (___) _____ Employer: _____

Who is responsible for making appointments?

Name: _____

Home Phone #: (___) _____ Work Phone #: (___) _____ Cell Phone#: _____

Insurance Information

Primary

Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (___) _____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthday: ___/___/___ Social Security #: _____ Policy Owner's Employer: _____

Secondary

Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (___) _____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthday: ___/___/___ Social Security #: _____ Policy Owner's Employer: _____

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Medical History

Child's Physician: _____ Phone #: (____) _____ Date of last Visit: _____

Address: _____

Is the child currently under the care of a physician? ❑ Yes ❑ No Please explain: _____

Please describe child's current physical health: ❑ Good ❑ Fair ❑ Poor Are immunizations current? ❑ Yes ❑ No

Please list all drugs that the child is currently taking: _____

Please list all drugs/materials that cause the child allergic reactions: _____

Is there anything you would like to discuss with the Doctor in private? ❑ Yes ❑ No

Has the child had/experienced any of the following:

Abnormal Bleeding	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No
AIDS/HIV+	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Lupus	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Handicaps/Disabilities	❑ Yes	❑ No	Measles	❑ Yes	❑ No
Allergies	❑ Yes	❑ No	Hearing Impairment	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No
Any Hospital Stays/Operations	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Mononucleosis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Hemophilia	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Blood Transfusion	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Sickle Cell Anemia	❑ Yes	❑ No
Chicken Pox	❑ Yes	❑ No	Hives	❑ Yes	❑ No	Skin Rash	❑ Yes	❑ No
Congenital Heart Defect	❑ Yes	❑ No	Kidney Problems	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No
Convulsions	❑ Yes	❑ No	Liver Problems	❑ Yes	❑ No	Tuberculosis (TB)	❑ Yes	❑ No

Please discuss any serious medical problems the child experiences/ed: _____

_____

Dental History

Is the child currently in pain? ❑ Yes ❑ No **What is the primary reason for today's visit?** _____

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Has the child experienced problems with previous dental work? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No Is the child taking fluoridated supplements? ❑ Yes ❑ No

Does the child brush his/her teeth daily? ❑ Yes ❑ No Does the child floss his/her teeth daily? ❑ Yes ❑ No

(❑ Previous ❑ Present) Dentist: _____ Date of last visit: _____

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least? _____

Does/did the child have any of the following habits?

Lip Sucking/Biting	❑ Yes	❑ No	Clenching/Grinding Teeth	❑ Yes	❑ No	Tongue/Cheek Biting	❑ Yes	❑ No
Nail Biting	❑ Yes	❑ No	Used Pacifier	❑ Yes	❑ No	Speech Problems	❑ Yes	❑ No
Chewing on Objects	❑ Yes	❑ No	Nursing Bottle Habits	❑ Yes	❑ No	Tongue Thrust	❑ Yes	❑ No
Mouth Breather	❑ Yes	❑ No	Thumb/Finger Sucking	❑ Yes	❑ No	Breast Fed	❑ Yes	❑ No

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. My method of payment will be: _____.

_____

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. Riebe all insurance benefits otherwise payable to payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

The parent or guardian who accompanies the child is responsible for payment at time of service.