Welcome

CHART:

We want to help you have the brightest smile possible. Please fill out this form completely so we can know how to be help your child reach maximum oral health.
The better we know your child, the better we can care for them.

YOUR CHILD'S NAME: ☐ MALE ☐ FEMALE

BIRTHDATE: **SS#:** - -

STREET ADDRESS:

CITY: **STATE:** **ZIP:**

E-MAIL ADDRESS:

HOME PHONE: **MOBILE:**

OFFICE PHONE:

SCHOOL: **GRADE:**

DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? ☐ YES ☐ NO

BEST TIME TO REACH YOU:

WHO MAY WE THANK FOR REFERRING YOU?

OTHER FAMILY MEMBERS SEEN BY US:

PREVIOUS DENTIST:

PHONE #: **LAST VISIT THERE:**

MOTHER'S NAME: **BIRTHDATE:**

MOBILE PHONE: **SS#:** - -

EMPLOYER: **PHONE:**

EMPLOYER ADDRESS:

FATHER'S NAME: **BIRTHDATE:**

MOBILE PHONE: **SS#:** - -

EMPLOYER: **PHONE:**

EMPLOYER ADDRESS:

DENTAL COVERAGE? ☐ YES ☐ NO

PRIMARY INSURANCE CO. NAME:

MEMBER/SUBSCRIBER ID:

PHONE:

POLICY HOLDER'S NAME:

POLICY HOLDER'S BIRTHDATE:

SECONDARY DENTAL COVERAGE? ☐ YES ☐ NO

SECONDARY INSURANCE CO. NAME:

MEMBER/SUBSCRIBER ID:

PHONE:

POLICY HOLDER'S NAME:

POLICY HOLDER'S BIRTHDATE:

DOES THE CHILD HAVE A PERSONAL PHYSICIAN? ☐ YES ☐ NO

PHYSICIAN NAME:

PHONE:

DATE OF LAST VISIT:

IS YOUR CHILD UNDER CARE OF THIS DOCTOR NOW?

EMERGENCY CONTACT:

RELATIONSHIP:

HOME PHONE: **MOBILE:**

STREET ADDRESS:

CITY: **STATE:** **ZIP:**

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MY CHILD'S CURRENT HEALTH IS: ☐ GOOD ☐ FAIR ☐ POOR

HAS YOUR CHILD SMOKED OR USED TOBACCO IN ANY OTHER FORM? ☐ YES ☐ NO

HAS YOUR CHILD EVER HAD ANY METAL RODS, PINS OR IMPLANTS? ☐ YES ☐ NO

IS YOUR CHILD TAKING ANY PRESCRIPTION/OVER-THE-COUNTER OR HERBAL SUPPLEMENT DRUGS?

☐ YES ☐ NO **IF YES, PLEASE LIST BELOW:**

DOES YOUR CHILD HAVE ANY OF THESE HABITS?

☐ LIP SUCKING/BITING
☐ THUMB-SUCKING
☐ NAIL BITING
☐ NURSING BOTTLE HABITS

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING?

☐ ASPIRIN
☐ DENTAL ANESTHETICS
☐ JEWERLY/METALS
☐ PENICILLIN
☐ OTHER (**PLEASE LIST**):
☐ CODEINE
☐ ERYTHROMYCIN
☐ LATEX
☐ TETRACYCLIN

WHY HAVE YOU BROUGHT YOUR CHILD TO THE DENTIST TODAY?

DOES YOUR CHILD REQUIRE ANTIBIOTICS BEFORE TREATMENT? ☐ YES ☐ NO

IS YOUR CHILD CURRENTLY IN PAIN? ☐ YES ☐ NO

HAS YOUR CHILD EVER HAD A SERIOUS PROBLEM RELATED TO ANY PAST DENTAL WORK? ☐ YES ☐ NO

IF YES, WHAT?

HAS YOUR CHILD EVER HAD GUM TREATMENT? ☐ YES ☐ NO

HAS YOUR CHILD EVER EXPERIENCED DISCOMFORT IN THEIR JAW (TMJ/TMD)? ☐ YES ☐ NO

DO YOUR CHILD'S GUMS EVER BLEED? ☐ YES ☐ NO

HOW MANY TIMES A WEEK DOES YOUR CHILD FLOSS?

HOW MANY TIMES A DAY DO THEY BRUSH?

TYPE OF BRISTLES? ☐ HARD ☐ MEDIUM ☐ SOFT

HOW OFTEN DO YOU REPLACE YOUR CHILD'S TOOTHBRUSH?

ARE YOUR CHILD'S TEETH SENSITIVE TO HEAT, COLD OR ANYTHING ELSE? ☐ YES ☐ NO

HAS YOUR CHILD LOST ANY TEETH? ☐ YES ☐ NO

LIST CAUSE:

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING DISEASES/ MEDICAL PROBLEMS?

☐ ABNORMAL BLEEDING/HEMOPHILIA
☐ AIDS/HIV
☐ ALCOHOL/DRUG ABUSE
☐ ANEMIA
☐ ARTHRITIS
☐ ARTIFICIAL BONES /JOINTS /VALVES
☐ ASTHMA
☐ BLOOD TRANSFUSION
☐ CANCER / CHEMOTHERAPY
☐ COLITIS
☐ CONGENITAL HEART DEFECT
☐ DIABETES
☐ DIFFICULTY BREATHING
☐ EMPHYSEMA
☐ EPLIEPSY / CONVULSIONS
☐ FAINTING SPELLS
☐ FREQUENT HEADACHES
☐ GLAUCOMA
☐ HAY FEVER
☐ HEART ATTACK / SURGERY
☐ HEART MURMUR
☐ HEPATITIS A B C
☐ HERPES / FEVER BLISTERS
☐ HIGH BLOOD PRESSURE
☐ HOSPITALIZED FOR ANY REASON
☐ KIDNEY PROBLEMS
☐ LIVER DISEASE
☐ LOW BLOOD PRESSURE
☐ LUPUS
☐ MITRAL VALVE PROLAPSE
☐ PACEMAKER
☐ PSYCHIATRIC PROBLEMS
☐ RADIATION TREATMENT
☐ RHEUMATIC / SCARLET FEVER
☐ SEIZURES
☐ SHINGLES
☐ SICKLE CELL DISEASE / TRAITS
☐ SINUS PROBLEMS
☐ STROKE
☐ THYROID PROBLEMS
☐ TUBERCULOSIS (TB)
☐ ULCERS
☐ VENEREAL DISEASE

ANYTHING YOU WOULD LIKE TO DISCUSS WITH THE DENTIST IN PRIVATE?

☐ YES ☐ NO

PLEASE LIST ANY OTHER SERIOUS MEDICAL CONDITION(S) THAT YOUR CHILD HAS HAD:

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

SIGNATURE: **DATE:** / /

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED. IF THIS OFFICE ACCEPTS INSURANCE, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AND ALSO RESPONSIBLE FOR PAYING ANY CO-PAYMENT AND DEDUCTIBLES THAT MY INSURANCE DOES NOT COVER. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL OFFICE OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORDS OF TREATMENT OR EXAMINATION RENDERED, TO MY INSURANCE COMPANY.

SIGNATURE: **DATE:** / /

A KIDS PLACE DENTISTRY
(801) 747-8000