WELCOME! to Dental Care 4 Kids

TELL US ABOUT YOUR CHILD

Today's Date: ____________________

Patient's Name: ____________________

Date of Birth: ____________ Age: ________

Social Security #: ____________________

Nickname: ____________ M ______ F ______

School: ____________________

Home Address: ____________________

____

Home Phone: ____________________

FATHER'S INFORMATION

☐ Guardian ☐ Step

Name: ____________________

DOB: ____________ DL#: ____________

Employer: ____________________

Home #: ____________ Work #: ____________

MOTHER'S INFORMATION

☐ Guardian ☐ Step

Name: ____________________

DOB: ____________ DL#: ____________

Employer: ____________________

Home # ____________ Work #: ____________

Who is accompanying the child today?

Name: ____________________

Relation: ____________________

Do you have legal custody of this child? ☐ Yes ☐ No

In case of an emergency, please call:

Name: ____________________

Phone #: ____________________

Other family members seen by us: ____________________

____

Name and Phone # of nearest relative not living with you: ____________

____

PERSON RESPONSIBLE FOR ACCOUNT

Name: ____________________

Relation: ____________________

Mailing Address: ____________________

____

Home #: ____________ Work #: ____________

Who may we thank for referring you?

______ Patient ______ Doctor ______ Other

Name: ____________________

Address: ____________________

____

Phone #: ____________________

INSURANCE INFORMATION

Insured's Name: ____________________

Insured's Birthday: ____________________

Insured's S.S. #: ____________________

Relationship to Patient: ____________________

Employer: ____________________

Employer's Address: ____________________

____

Work Phone#: ____________ Ext.: ______

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

____

____

Insurance Co. Phone #: ____________________

Group# (Plan, Local, or Policy): ____________________

For our patients with dental insurance, we will accept payment for treatment directly from your insurance company; however, we ask you to pay non-covered fees as treatment progresses. If we do not receive payment within five (5) weeks after the completion of treatment, you will be expected to pay for all dental services. In the event of duplicate payment, you will be reimbursed.

____

Signature of Parent or Guardian Date

Previous / Present Dentist: ____________________

____

____

Child's Physician: ____________________

Phone #: ____________________ Date of Last Visit: __________

Is this child currently under the care of a physician?
☐ Yes ☐ No

Please describe the child's current physical health
☐ Good ☐ Fair ☐ Poor

____

Please list all drugs that the child is currently taking

____

____

Please list all drugs that the child is allergic to

____

____

Does the child have any of the following habits?

Yes	No	
☐	☐	Thumb / Finger Sucking
☐	☐	Lip Sucking / Biting
☐	☐	Nail Biting
☐	☐	Nursing / Bottle Habits
☐	☐	Mouth Breathing
☐	☐	Nighttime Grinding of Teeth

Does the child have/or ever had any of the following medical problems?

Does your child have a Heart Condition? ☐ Yes ☐ No

Explain: ____________________

If yes, Child's Cardiologist and phone #: ____________________

____

Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	Convulsions/Seizures
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Hearing Impaired
☐	☐	HIV + / AIDS	☐	☐	Any Operations
☐	☐	Hemophilia / Anemia	☐	☐	Any stays in a hospital
☐	☐	Asthma	☐	☐	Kidney / Liver Problems
☐	☐	Hepatitis	☐	☐	Handicaps / Disabilities
☐	☐	Tuberculosis (TB)	☐	☐	Allergies
☐	☐	Chronic upper respiratory problems	☐	☐	Pregnant
			☐	☐	ADD or ADHD

Please discuss any serious medical problems that the child has had

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____

What is the reason for today's visit? ____________________

____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform any necessary dental services my child may need. "We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice."

____

Signature of parent or guardian Date

____

Signature of person accompanying child Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.