# Welcome
# 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 #: ____________

Cell #: ____________

## MOTHER'S INFORMATION

☐ Guardian ☐ Step

Name: ______________________

DOB: ____________ DL#: ____________

Employer: ______________________

Home #: ____________ Work #: ____________

Cell #: ____________

**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

*Please Continue on other side*

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 / Nail Biting |
| ☐ | ☐ | Snoring / Sleep Apnea |
| ☐ | ☐ | Nursing / Bottle Habits |
| ☐ | ☐ | Mouth Breathing |
| ☐ | ☐ | Nighttime Grinding of Teeth |
| ☐ | ☐ | Does your child use fluoride at home? |

**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 #: _________________

Have you ever been told your child requires antibiotic premedication? ☐ Yes ☐ No

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Cancer | ☐ | ☐ | Convulsions/Seizures |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Abnormal Bleeding |
| ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | Hearing Impairment |
| ☐ | ☐ | 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 |
| ☐ | ☐ | Autism | ☐ | ☐ | GE Reflux |

Please discuss any serious medical problems that the child has had ______________________________________________

____________________________________________________

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

Prefer Email? Please list address below:

____________________________________________________

____________________________________________________

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.*