Welcome to Kid's dental

PATIENT INFORMATION

Birthdate: _____

Name of Minor/Child _____ Sex M F
(Last name) (First Name) (Middle Initial)

Home Address _____
(Street) (City) (State) (Zip)

Person financially responsible _____ Home (____) _____ Cell (____) _____

Email address: _____ Work (____)_____

Whom may we thank for referring you? _____ (OR) How did you hear about us? _____

Father's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone (____) _____ Cell Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? Yes No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's /Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone (____) _____ Cell Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer_____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? Yes No

Plan Name _____ Phone(____) _____

Address _____

Group # _____ Policy # _____

Insurance is a contract between you and your insurance company. We will bill your insurance as a courtesy to you, but note that payment is due at time of service. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your benefits. You must agree to pay any portion of the charges not covered by the insurance.
I hereby authorize payment by my dental insurance company be paid directly to Kid's Dental. I also authorize the release of any dental information necessary to process all dental claims. At the discretion of the office we may use services of one or more credit reporting services. I acknowledge receipt of privacy practices.
PLEASE LET THIS NOTICE SERVE TO NOTIFY YOU THAT IF YOU DO NOT CALL BY 4 O'CLOCK THE DAY BEFORE YOUR APPOINTMENT (AND/OR) YOU REPEATEDLY "NO SHOW" FOR YOUR SCHEDULED APPOINTMENT TIME; THERE WILL BE A $25.00 FEE BILLED TO YOUR ACCOUNT THAT CANNOT BE FILED TO YOUR INSURANCE AND YOU ARE RESPONSIBLE FOR THE FULL AMOUNT.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

kid's dental

DENTAL HISTORY

Child's Name: _____ Date of Birth: ____/____/_____ ❑ Male ❑ Female

How did you hear about us? _____

Does your child have a history of any of the following:

❑ Nursing/ Bottle Habits ❑ Pacifier ❑ Thumb/Finger Sucking ❑ Dental Grinding

MEDICAL HISTORY

Name of Child's Physician: _____ Phone: _____

Is Child currently taking any medications? ❑ YES ❑ NO If yes, what? _____

Is child allergic to any of the following medications or substances? ❑ YES ❑ NO

❑ Aspirin ❑ Penicillin ❑ Latex ❑ Foods ❑ Metal/Acrylics ❑ Other: _____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS

AIDS/HIV ❑ YES ❑ NO	Cerebral Palsy ❑ YES ❑ NO	Growth Problems ❑ YES ❑ NO	Orthopedic Problems ❑ YES ❑ NO
Anemia ❑ YES ❑ NO	Chemotherapy ❑ YES ❑ NO	Heart Murmur/ Heart Problems ❑ YES ❑ NO	Tobacco Use ❑ YES ❑ NO
Allergies ❑ YES ❑ NO	Child Abuse ❑ YES ❑ NO	Hepatitis/ Liver Disease ❑ YES ❑ NO	Pregnancy ❑ YES ❑ NO
Asthma/Breathing Problems ❑ YES ❑ NO	Chronic Adenoid/ Tonsil Problems ❑ YES ❑ NO	High Blood Pressure ❑ YES ❑ NO	Ulcers ❑ YES ❑ NO
Autism ❑ YES ❑ NO	Cleft Lip/Palate ❑ YES ❑ NO	Bladder Conditions ❑ YES ❑ NO	Diabetes ❑ YES ❑ NO
Arthritis ❑ YES ❑ NO	Developmentally Delayed ❑ YES ❑ NO	Kidney Disease ❑ YES ❑ NO	Disabilities/ Special Needs ❑ YES ❑ NO
ADHD ❑ YES ❑ NO	Drug/Alcohol Use ❑ YES ❑ NO	Leukemia ❑ YES ❑ NO	Speech/Hearing Problems ❑ YES ❑ NO
Birth Defects ❑ YES ❑ NO	Emotional Disturbance ❑ YES ❑ NO	Sickle Cell Anemia ❑ YES ❑ NO	Convulsions/ Seizures ❑ YES ❑ NO
Brain Injury ❑ YES ❑ NO	Excessive Gagging ❑ YES ❑ NO	Tuberculosis ❑ YES ❑ NO	Tumors / Growths ❑ YES ❑ NO
Bruise Easily ❑ YES ❑ NO	Fainting/Dizziness ❑ YES ❑ NO	Prosthetic Joints/ Pins ❑ YES ❑ NO	Psychiatric Care ❑ YES ❑ NO
Bleeding/ Clotting Problems ❑ YES ❑ NO	Fever Blisters ❑ YES ❑ NO	MRSA ❑ YES ❑ NO	
Cancer ❑ YES ❑ NO			

If you answered "Yes" to any of the above, please explain: _____

_____

PARENT/GUARDIAN SIGNATURE: _____ Date: ___/___/___ Dr.'s Signature: _____ Date: ___/___/___

HEALTH HISTORY UPDATE/CHANGES

DATE	CHANGE	NO CHANGE	GUARDIAN SIGNATURE	DOCTOR'S SIGNATURE

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