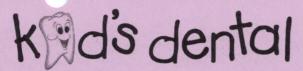
## Welcome to Kilds dental

| PATIENT INFORMATION              |  |                                      |  |  |  |  |  |
|----------------------------------|--|--------------------------------------|--|--|--|--|--|
|                                  | Birthdate:   |                                      |  |  |  |  |  |
| STATISTICS OF THE PERSONS        | Name of Minor/Child Sex M F (Last name) (First Name)   |                                      |  |  |  |  |  |
| -                                | Home Address (City) (State) (Zip)  |                                      |  |  |  |  |  |
|                                  | Person financially responsible         Home ()         Cell ()   |                                      |  |  |  |  |  |
|                                  | Email address: Work ()   |                                      |  |  |  |  |  |
| Ì                                | Whom may we thank for referring you? (OR) How did you hear about us?   |                                      |  |  |  |  |  |
| 1                                | Father's/Guardian's Name Mother's /Guardian's Name   | TOTAL CONTRACTOR                     |  |  |  |  |  |
|                                  | Address (if different from patient's) Address (if different from patient's)  |                                      |  |  |  |  |  |
| STATEMENT OF THE PERSON NAMED IN | Home Phone () Cell Phone () Home Phone () Cell Phone () (if different from above) (if different from above)  |                                      |  |  |  |  |  |
| -                                | E-mail   |                                      |  |  |  |  |  |
| -                                | Employer Employer  |                                      |  |  |  |  |  |
| -                                | Soc. Sec. # Birthdate Box Sec. # Birthdate | -                                    |  |  |  |  |  |
| 1                                | Do you have dental insurance coverage for minor/child? Yes No Do you have dental insurance coverage for minor/child?   | 2000                                 |  |  |  |  |  |
|                                  | Tidi Tidi Cara Cara Cara Cara Cara Cara Cara Car   | -                                    |  |  |  |  |  |
|                                  | Address  | THE PERSON NAMED IN                  |  |  |  |  |  |
| THE REAL PROPERTY.               |  | Section 1                            |  |  |  |  |  |
|                                  | 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.  |                                      |  |  |  |  |  |
| 1                                | Signature of Parent, Guardian or Personal Representative Date  | Name and Address of the Owner, where |  |  |  |  |  |



## **DENTAL HISTORY** ☐ Male Date of Birth: / Child's Name: ☐ Female How did you hear about us? Does your child have a history of any of the following: Dental Grinding ☐ Thumb/Finger Sucking ☐ Pacifier ☐ Nursing/ Bottle Habits MEDICAL HISTORY Phone: Name of Child's Physician: Is Child currently taking any medications? ☐ YES ☐ NO If yes, what? Is child allergic to any of the following medications or substances? ☐ YES ☐ NO □ Foods ☐ Metal/Acrylics Other: □ Latex □ Penicillin ☐ Aspirin PLEASE ANSWER ALL THE FOLLOWING QUESTIONS Orthopedic ☐ YES ☐ NO Growth Problems ☐ YES ☐ NO Cerebral Palsy AIDS/HIV ☐ YES ☐ NO ☐ YES ☐ NO Problems □ YES □ NO Chemotherapy ☐ YES ☐ NO Heart Murmur/ YES NO Anemia Tobacco Use ☐ YES ☐ NO Heart Problems ☐ YES ☐ NO Child Abuse ☐ YES ☐ NO Allergies Pregnancy ☐ YES ☐ NO Hepatitis/ ☐ YES ☐ NO Liver Disease Asthma/Breathing ☐ YES ☐ NO Chronic Adenoid/ ☐ YES ☐ NO Ulcers ☐ YES ☐ NO **Tonsil Problems** Problems High Blood Pressure ☐ YES ☐ NO ☐ YES ☐ NO Diabetes ☐ YES ☐ NO Autism Cleft Lip/Palate ☐ YES ☐ NO Bladder Conditions YES NO □ YES □ NO Disabilities/ Arthritis ☐ YES ☐ NO Developmentally ☐ YES ☐ NO Special Needs Delayed Kidney Disease ☐ YES ☐ NO ADHD ☐ YES ☐ NO ☐ YES ☐ NO Speech/Hearing Drug/Alcohol Use YES NO ☐ YES ☐ NO Leukemia Birth Defects ☐ YES ☐ NO Problems ☐ YES ☐ NO **Emotional** Sickle Cell Anemia YES NO **Brain Injury** ☐ YES ☐ NO Convulsions/ ☐ YES ☐ NO Disturbance Seizures **Tuberculosis** ☐ YES ☐ NO ☐ YES ☐ NO Bruise Easily Excessive Gagging QYES QNO Tumors / Growths ☐ YES ☐ NO Prosthetic Joints/ ☐ YES ☐ NO Bleeding/ □ YES □ NO Fainting/Dizziness ☐ YES ☐ NO Pins Clotting Problems Psychiatric Care ☐ YES ☐ NO Fever Blisters ☐ YES ☐ NO **MRSA** ☐ YES ☐ NO ☐ YES ☐ NO Cancer If you answered "Yes" to any of the above, please explain: Date: / Dr.'s Signature: PARENT/GUARDIAN SIGNATURE: **HEALTH HISTORY UPDATE/CHANGES**

| DATE | CHANGE | NO CHANGE | GUARDIAN SIGNATURE | DOCTOR'S SIGNATURE |
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