# KIDS TOWN PEDIATRIC DENTISTRY

**PATIENT INFORMATION** **Today's Date**

**_____/_____/_____**

Welcome to our dental office, where we provide individualized care for infants, toddlers, children and special needs patients. Our focus is on prevention and early management of dental disease. We are honored that you have entrusted your child's care to us. We take great pride in

How did you hear about us? ☐Internet/Google ☐Facebook ☐Drive by ☐HTV or Value Pages

☐Insurance ☐Patient/Parent:_____☐Other:_____

☐Doctor Referred:_____

providing a comfortable experience for children and their families.

## CHILD INFO

Name: _____ Goes by: _____

Birth date: _____/_____/_____ ☐Male ☐Female

Home address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

## PARENT/GUARDIAN INFO ☐Mom ☐Dad ☐Guardian / ☐Married ☐Divorced ☐Single

Name: _____ Goes by: _____

D.O.B. _____/_____/_____ Social Security #: _____/_____/_____

Address: (if different than child's) _____

City: _____ State: _____ Zip: _____

Best contact phone #: _____☐Home ☐Cell ☐Work

Email: _____ Driver's License #_____

## PARENT/GUARDIAN INFO ☐Mom ☐Dad ☐Guardian / ☐Married ☐Divorced ☐Single

Name: _____ Goes by: _____

D.O.B. _____/_____/_____ Social Security #: _____/_____/_____

Address: (if different than child's) _____

City: _____ State: _____ Zip: _____

Best contact phone #: _____☐Home ☐Cell ☐Work

Email: _____Driver's License #_____

Is there anyone you would like to designate to bring your child in for dental appointments other than mom/dad? If yes, please list: _____Relationship: _____

EMERGENCY CONTACT: Please list a name and phone number of someone we can contact other than mom/dad: _____ Phone: _____

*If you have BCBS or GEHA Medical Insurance you may have limited dental coverage that we would be required to bill as primary so please list if this applies to your child.

**DENTAL INSURANCE PRIMARY**

Insurance Company name: _____

Insurance contact phone number: _____

Policy/Subscriber Name: _____

Policy/Subscriber Birth date: _____/_____/_____ Social Security #_____

Policy/Subscriber Number: _____ Group #_____

Group Name: _____ Employer: _____

Relationship to patient: ☐Mom ☐Dad ☐Step-parent ☐Grandparent / Guardian

**DENTAL INSURANCE SECONDARY**

Insurance company name: _____

Insurance Contact phone number: _____

Policy/Subscriber Name: _____

Policy/Subscriber birth date: _____/_____/_____ Social Security #_____

Policy/Subscriber Number: _____ Group #_____

Group Name: _____Employer: _____

Relationship to patient: ☐Mom ☐Dad ☐Step-parent ☐Grandparent / Guardian

Please be aware that the Insurance you provide to us is a contract between you and your Insurance carrier. **YOU are responsible for knowing your Insurance benefits including Maximums, Deductibles, Co-Insurance and Co-pays.** We will submit your Insurance and do what is within our power to help you receive your Insurance benefits for the procedures we provide. However, if the Insurance does not pay for specific procedures you understand that it will be YOUR responsibility to pay the difference IN FULL on the date of treatment or within 30 days if the Insurance denies payment.

**_____ Initial that you read and understand your Insurance responsibility**

# KIDS TOWN PEDIATRIC DENTISTRY

## Patient Health History

**PATIENT NAME: _____DOB: _____/_____/_____**

**DENTAL HISTORY:**

Why is your child here today? ☐First Dental Visit ☐Checkup ☐Other_____

Has your child been to the Dentist before? ☐Yes ☐No If yes, date? _____

How was your child's experience (check one) ☐Excellent ☐Good ☐Fair ☐Poor?

Has your child had dental x-rays taken before? ☐Yes ☐No

Is your child currently taking fluoride? ☐Yes ☐No If yes, how often? _____ x daily

Does the patient have any of the following oral habits?
☐finger or thumb sucking ☐pacifier ☐nail biting ☐lip sucking ☐biting ☐grinding

Is the patient breast feeding or still on a bottle? ☐Yes ☐No Using sippy cup? ☐Yes ☐No

**AT HOME DENTAL CARE:**
How often does your child brush their teeth? _____ x daily. Who brushes? ☐Child ☐Parent
How often does your child floss their teeth? _____ x daily. Who flosses? ☐Child ☐Parent

**MEDICAL HISTORY:**

Name of Primary Physician? _____
Date of last Medical exam? _____Are your child's shots current? ☐Yes ☐No
Is your child currently under the care of a physician for any reason? ☐Yes ☐No
If yes, what for? _____
Has your child ever had a traumatic medical/dental related injury? ☐Yes ☐No
If yes, what? _____When?_____
Has your child ever been hospitalized? ☐Yes ☐No
If yes, what for? _____When? _____

# Health History(continued)

Patient Name: _____ DOB: ____/____/____

**Does the patient have or have they ever had any of the following?**

| | YES | NO |
|---|---|---|
| ADD/ADHD | ☐ | ☐ |
| AIDS/HIV Positive | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Autism/Spectrum disorder | ☐ | ☐ |
| Blood Disease | ☐ | ☐ |
| Specifically:_____ | | |
| Cancer | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ |
| Cerebral Palsy | ☐ | ☐ |
| Cleft lip | ☐ | ☐ |
| Cleft Palate | ☐ | ☐ |
| Congenital Birth defect | ☐ | ☐ |
| Specifically:_____ | | |
| Congenital Heart Defect | ☐ | ☐ |
| Developmental delay | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Down Syndrome | ☐ | ☐ |
| Endocrine Disorder | ☐ | ☐ |
| Epilepsy or Seizures | ☐ | ☐ |
| Excessive Bleeding | ☐ | ☐ |
| GI System Condition | ☐ | ☐ |
| Heart Condition | ☐ | ☐ |
| Specifically:_____ | | |

| | YES | NO |
|---|---|---|
| Heart Murmur | ☐ | ☐ |
| Heart Surgery | ☐ | ☐ |
| Hearing impaired | ☐ | ☐ |
| Hepatitis A, B or C | ☐ | ☐ |
| Kidney Problems | ☐ | ☐ |
| Leukemia | ☐ | ☐ |
| Liver Disease/Problem | ☐ | ☐ |
| Mental Disability / Disorder | ☐ | ☐ |
| Physical Disability | ☐ | ☐ |
| Premature Birth | ☐ | ☐ |
| Pregnancy | ☐ | ☐ |
| If yes, due date:_____ | | |
| Radiation Treatment | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ |
| Sickle Cell Anemia or Trait | ☐ | ☐ |
| Sinus Trouble | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Thyroid or other gland disorder | ☐ | ☐ |
| Tonsillitis | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Tumors or Growths | ☐ | ☐ |
| Vision impaired | ☐ | ☐ |
| Venereal Disease | ☐ | ☐ |
| Other | ☐ | ☐ |
| Please list_____ | | |

**DOES YOUR CHILD HAVE ALLERGIES TO ANY OF THE FOLLOWING:**

☐Local Anesthetic ☐Penicillin / Amoxicillin ☐Sulfa ☐Latex ☐Codeine ☐Other_____

**Please list any medications your child is on and what they are taking it for:**

_____

The information I have given is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical status.

_____ _____

Signature of parent or guardian Date