

# 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 providing a comfortable experience for children and their families.

How did you hear about us?  Internet/Google  Facebook  Drive by  HTV or Value Pages  
 Insurance  Patient/Parent: \_\_\_\_\_  Other: \_\_\_\_\_  
 Doctor Referred: \_\_\_\_\_

## 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

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

	YES	NO		YES	NO
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impaired	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B or C	<input type="checkbox"/>	<input type="checkbox"/>
Autism/Spectrum disorder	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Specifically: _____			Liver Disease/Problem	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disability / Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Premature Birth	<input type="checkbox"/>	<input type="checkbox"/>
Cleft lip	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Cleft Palate	<input type="checkbox"/>	<input type="checkbox"/>	If yes, due date: _____		
Congenital Birth defect	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Specifically: _____			Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid or other gland disorder	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
GI System Condition	<input type="checkbox"/>	<input type="checkbox"/>	Vision impaired	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Specifically: _____			Other	<input type="checkbox"/>	<input type="checkbox"/>
			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:

\_\_\_\_\_

<p>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.</p>	
<p>_____</p> <p>Signature of parent or guardian</p>	<p>_____</p> <p>Date</p>