



Date: _____

Patients Name: _____ (First/Last) Nickname: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birth date: ___/___/___ SS#: _____
(Circle One)

Name of Responsible Party: _____ Relationship to Patient: _____
(First/Last)

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birth date: ___/___/___ Single Married Widow Separated Divorced SS#: _____
(Circle One)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Family Member Information

Please list the names of your spouse and children.	Is person a patient?		Sex		Age	Date of birth
	Yes	No	M	F		

Please list the names of your spouse and children.	Is person a patient?		Sex		Age	Date of birth
	Yes	No	M	F		

Who may we thank for referring you to our office? _____

INSURANCE INFORMATION

Policy Holders Name: _____ Relationship to Patient: _____ SS#: _____ DOB ___/___/___

Name of Employer: _____ Employer Address: _____ State: _____

Insurance Co. _____ Group #: _____ Address: _____

Secondary Insurance Information

Policy Holders Name: _____ Relationship to Patient: _____ SS#: _____ DOB ___/___/___

Name of Employer: _____ Employer Address: _____ State: _____

Insurance Co. _____ Group #: _____ Address: _____

I certify that all the information (including medical, personal, and insurance records) is true and complete. I give my full permission to Dental Care Kids to check and verify my credit and/or employment history. I further understand that Dental Care Kids will assist me in filing my child's claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan.

I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my child's photos for educational purposes.

I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient.

We require 48 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due at the rate of 1.5% per month. Thank you for your cooperation.

Parent or Guardian: _____

(please complete both sides)

Dental History

	Yes	No
1. Is this your child's first visit to a dentist?..... When was the last dental visit? _____	_____	_____
2. Were any x-rays taken previously?.....	_____	_____
3. Has your child had any problem with dental treatment in the past?	_____	_____
4. Has your child ever received a local anesthetic (novocaine)?.....	_____	_____
5. Have any cavities been diagnosed in the past?.....	_____	_____
6. Has your child ever had occlusal sealants?	_____	_____
7. Were any teeth removed by extraction?.....	_____	_____
8. Has your child or anyone in the immediate family ever had braces?	_____	_____
9. Does your child snack between meals?	_____	_____
What are their preferred snacks? _____		
10. Does your child drink from a bottle or sippy cup?.....	_____	_____
11. Does your child suck their thumb or use a pacifier?.....	_____	_____
12. How often does your child brush his/her teeth? _____		
13. How often do they floss?_____ Does a parent help brush and floss?	_____	_____
14. Do you have fluoridated water at home?	_____	_____
15. Does your child drink at least 2 cups of this water per day?	_____	_____
16. Does your child receive fluoride supplements?.....	_____	_____
What kind and how often? _____		
17. Have there been any injuries to teeth, such as falls, blows, chips, etc.?.....	_____	_____
18. Do you have any concerns about your child's teeth? _____	_____	_____

Medical History

	Yes	No
1. Physicians Name _____ Telephone () _____		
2. Is your child under care of physician now?..... Since when and why? _____	_____	_____
3. Does your child take any medications, vitamins, or herbal supplements?..... Please list _____	_____	_____
4. Is your child allergic to anything? Antibiotics, metals, foods, latex, other?	_____	_____
Please list _____		
5. Did your child ever require hospitalization?..... When? _____ Why? _____	_____	_____
6. Does your child get headaches?.....	_____	_____
7. Does your child require antibiotic premedication before dental visits?.....	_____	_____
8. Does your child have, or have they ever had, any of the following:		

	Yes	No		Yes	No
Anemia	_____	_____	AIDS / HIV positive	_____	_____
Asthma or hay fever	_____	_____	Cancer	_____	_____
Behavioral/Learning problems	_____	_____	Excessive urination	_____	_____
Cerebral Palsy	_____	_____	Heart murmur/MVP	_____	_____
Congenital birth defects	_____	_____	Hepatitis	_____	_____
Diabetes	_____	_____	Kidney infection	_____	_____
Dizziness/Fainting	_____	_____	Liver problems	_____	_____
Eyesight problems	_____	_____	Reoccurring infections	_____	_____
Hearing loss	_____	_____	Rheumatic fever	_____	_____
Persistent cough	_____	_____	Severe or prolonged bleeding	_____	_____
Sinus trouble	_____	_____	Tuberculosis	_____	_____
Speech impairments	_____	_____	Ulcers	_____	_____