PATIENT INFORMATION

☐ Male
☐ Female

Last Name | First name | Prefers to be addressed by

Date of Birth | Age | Other family members treated at this office

Address | Apt # | City | State | Zip

Home Telephone | Emergency Contact Name | Emergency Contact Telephone

PARENT/GUARDIAN

☐ Male
☐ Female

First & Last Name | Date of Birth

Social Secuirty # | Cell Phone #

Email Address

☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Separated ☐ Guardian

Employer | Telephone

Address

Complete if **DIFFERENT** from Patient's home information

Address

Phone Number

PARENT/GUARDIAN

☐ Male
☐ Female

First & Last Name | Date of Birth

Social Secuirty # | Cell Phone #

Email Address

☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Separated ☐ Guardian

Employer | Telephone

Address

Complete if **DIFFERENT** from Patient's home information

Address

Phone Number

INSURANCE INFORMATION

PRIMARY INSURANCE

Company

Address

City | State | Zip

Insurance Telephone | Policy/Group #

Policy Holder | Relationship to Patient

SECONDARY INSURANCE

Company

Address

City | State | Zip

Insurance Telephone | Policy/Group #

Policy Holder | Relationship to Patient

REFERRAL INFORMATION

How did you hear about our office?

DENTAL HISTORY

Patient's Name _____ Date of Birth _____

Previous Dentist (if any) _____ Date of Last Dental Exam _____

What concerns you most about your child's dental health? _____ Dental Pain? (Y / N) _____ Level of Pain (1-10) _____

Mouth Habits? **Please check all that apply.**

☐ Thumb Sucking ☐ Pacifier ☐ Mouth Breather ☐ Still on Bottle ☐ Finger Habit ☐ Tooth Grinding ☐ None

Has your child had a negative dental experiencein the past? If yes, please explain _____

How often does your child brush? _____ How often does your child floss? _____ Has your child received fluoride supplements? If yes, what kind? _____

Are you happy with the appearance of your child's teeth? _____

MEDICAL HISTORY

Name/Practice Name of Child's Pediatrician _____ Practice Telephone _____

Under care of a Physician at this time? (Y / N) Explain if neccessary _____ Taking any medication? (Y / N) If Yes, what? _____

Allergies? (Medications, food, latex, seasonal, etc) If Yes, what? _____ General Anesthesia? (Y / N) Please Explain _____

Ever had a serious illness or been hospitalized? (Y / N & Date) Please Explain _____ Does anyone in the family have history of malignant hyperthermia? If so, whom? _____

Advised to take antibiotic prior to dental treaments? (Y / N) _____ If yes, antibiotic name and method _____

Is there any other information that we should know about your child's health? _____

Please answer the following. Has your child ever had a history of:

Y	N		Y	N		Y	N	
☐	☐	ADD/ADHD	☐	☐	Diabetes	☐	☐	Jaw Pain
☐	☐	Anxiety or Depression	☐	☐	Earaches	☐	☐	Kidney Trouble
☐	☐	Artificial Heart Valve/Device	☐	☐	Emotional Problems	☐	☐	Leukemia
☐	☐	Asthma			_____	☐	☐	Liver Disease
☐	☐	Autism	☐	☐	Fainting Spells	☐	☐	Psychiatric Treatment
☐	☐	Birth Defects	☐	☐	GERD/Reflux	☐	☐	PTSD
☐	☐	Blind or Sight Impaired	☐	☐	Headaches	☐	☐	Respiratory Lung Disease
☐	☐	Blood Disorders/Bleeding Problems	☐	☐	Hearing/Impaired	☐	☐	Seizure Disorder
		_____			Cochlear Implant? _____			_____
☐	☐	Brain Injury	☐	☐	Heart Condition	☐	☐	Speech Problems
☐	☐	Cancer			Type? _____	☐	☐	Syndrome
☐	☐	Cerebral Palsy	☐	☐	Heart Murmur			_____
☐	☐	Cleft Lip/Palate	☐	☐	Heart Surgery Date _____	☐	☐	Other
☐	☐	Developmental Delayed	☐	☐	Kidney Trouble			_____

☐ **This child has never been diagnosed as having any of the above conditions**

I certify that the information given is correct and give consent to Kids First Pediatric Dentistry to treat my child.

_____ Parent Guardian Other _____

Signature Relationship to Patient (Please Circle) Date

_____ _____

Reviewed By Date