Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

Date:

Welcome TO Kidz Dental Land

Parent must be with Child/children For Appointment

PATIENT INFORMATION

Child's Name ____________________ Birthdate__________ Age_____Male _____Female____

Address____________________ City__________ State________ Zip________

Home Phone____________________ Cell Phone Number____________________

Any other family member (sibling) seen by our office? ____________________

Whom May We Thank For Referring You?____________________

Person to Contact In Case of Emergency?____________________ Phone__________

Pediatrician's Name____________________ Phone__________

MOTHERS INFORMATION

Name____________________Relation to Patient__________

Address____________________ City__________ State________ Zip________

Birthdate__________ Cell Phone #__________ Email __________

Check One: ___Single ___ Married ___Divorced ___Widowed ___ Separated ___Other

FATHERS INFORMATION

Name ____________________ Relation to Patient__________

Address____________________ City__________ State________ Zip________

Birthdate__________ Cell Phone #__________Email __________

Check One: ___Single ___ Married ___Divorced ___Widowed ___ Separated ___Other

DENTAL INSURANCE INFORMATION

Name of Insured____________________ Relation to Patient__________

Birthdate__________ Social Security #__________ Date Employed__________

Employer____________________ Work Phone__________

Employer Address____________________ City__________ State________ Zip________

Insurance Company____________________ Group #__________

Address____________________ City__________ State________ Zip________

DENTAL HISTORY

Reason for today's visit____________________ Date of last dental visit____________________

Former Dentist____________________ Date of last dental x-rays____________________

CHECK IF YOU HAVE ANY OF THE FOLLOWING:

__Bad Breath
__Bleeding gums
__Clinching or popping jaw
__Food collection between teeth
__Grinding teeth
__Loose teeth or broken fillings
__Periodontal treatment
__Sensitivity to cold
__Sensitivity to heat
__Sensitivity to sweets
__Sensitivity when biting
__Sores or growths in the mouth

How often do you floss?____________________ How often do you brush?____________________

MEDICAL HISTORY

Has the child experienced the following medical problems

PLEASE FILL OUT YES OR NO FOR THE QUESTIONS (PLEASE CHECK ALL THAT APPLY)

__Y__N Abnormal Bleeding/Hemophilia
__Y__N ADD/ADHD
__Y__N AIDS/HIV+
__Y__N Anemia
__Y__N Any Hospital Stays/Operations?
__Y__N Artificial Bones/Joints/Values
__Y__N Asthma
__Y__N Cancer
__Y__N Chicken Pox
__Y__N Congential Heart Defect
__Y__N Convulsions
__Y__N Diabetes
__Y__N Epilepsy
__Y__N Exposed to HIV, but Neg.
__Y__N Handicaps/Disabilities
__Y__N Hearing Impairment
__Y__N Lyme desease
__Y__N Heart Murmur
__Y__N Hepatitis
__Y__N High Blood Pressure
__Y__N Hives
__Y__N Kidney Problems
__Y__N Liver Problems
__Y__N Low Blood Pressure
__Y__N Lupus
__Y__N Measles
__Y__N Mitral Valve Prolapse
__Y__N Mononucleosis
__Y__N Prosthetics
__Y__N Rheumatic Fever
__Y__N Scarlet Fever
__Y__N Skin Rash
__Y__N Autism
__Y__N Other

Explain ____________________

Are the child's immunizations current? __Y__N

List all prescriptions/over the counter drugs that your child is currently taking:____________________

____

List all drugs/things that the child is allergic to:____________________

____

Our office is HIPPA compiant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____

Signature of Parent or Guardian **Date**

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein:

____

Signature of Dentist **Date**

MEDICAL HISTORY UPDATE

Has there been any change in your child's health status since their last visit? __Y__N

If Yes, please explain.____________________

____________________ ____________________

Parent/Guardian Signature **Date** **Dentist Signature** **Date**

Has there been any change in your child's health status since their last visit? __Y__N