kid's dental
General Dentistry for Kids

Braces
BracesBraces

Date ___ /___ / _____

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Name _____ Nickname _____
Last Name First Name Middle Initial

address _____ City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ DOB _____ / _____ / _____

Social Security # _____-_____-_____ Sex: ☐ M ☐ F

Grade _____ School/Daycare _____

Names/ages of other children in family: _____

How did you hear about us?

☐ Radio ☐ Television ☐ Insurance
☐ Internet ☐ Personal reference ☐ Walk-in
☐ Phonebook ☐ Local event _____ ☐ Other _____

In case of emergency who should we contact? _____ Phone _____

Person responsible for account _____

Primary Dental Insurance

Primary Insured's Information Only required below

Name _____
Last Name First Name Middle Initial

Relationship to Patient _____ DOB _____ / _____ / _____

Social Security # _____-_____-_____ Contact Number _____

address _____ City _____ State _____ ZIP _____

email address _____ Employer _____

Insurance Company _____ Phone _____

Subscriber ID # _____ Group # _____

Medicaid ID # _____ Carrier: TMHP / DentaQuest / MCNA Dental

CHIP ID # _____ Carrier: TMHP / DentaQuest / MCNA Dental

Guardian Signature _____ Date ___ /___ / _____

Health History

Your child's overall health as well as any medications which your child takes could have an important role with the dental care he/she receives. Please answer the following questions accurately and completely:

Has your child been to the dentist before? Yes ☐ No ☐ How would you rate your child's experience at the previous dentist's office? Good ☐ Bad ☐

How often does your child brush their teeth? _____ Floss? _____

Does your child take fluoride supplements? _____

Please mark "Yes" or "No" for the following questions regarding your child:

Yes	No		Yes	No	
☐	☐	Sucks finger/thumb	☐	☐	Chews on hard objects (pencils, etc.)
☐	☐	Sucks/bites lip	☐	☐	Grinds teeth
☐	☐	Bites/chews nails	☐	☐	Clenches jaws

Please mark below if applicable:

☐ Heart disease/murmur	☐ Bleeding/transfusions	☐ Asthma	☐ Blood dyscrasias
☐ Liver/GI disease	☐ Anemia	☐ Diabetes	☐ HIV/AIDS
☐ Kidney disease	☐ Rheumatic fever	☐ Hepatitis	☐ Mental delays
☐ Speech/hearing problems	☐ Seizures	☐ Cleft lip/palate	☐ Physical delays
☐ Cerebral palsy	☐ Congenital birth defects	☐ Personality/social	☐ Other problems _____
☐ Cancer/tumors	☐ Recurrent headaches	☐ Frequent infections	_____

Please explain any items checked above: _____

Please list any medications your child takes: _____

_____

Please list all previous hospitalizations/surgeries/illnesses: _____

Child's primary doctor: _____ Phone number: _____

Is your child allergic to latex or any medications? Yes ☐ No ☐ If so, please list: _____

Assignment and Release

I hereby authorize payment directly to Dr. _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____ / _____ / _____