WELCOME

Kitchens' Pediatric Dentistry

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nickname: _____ Male Female (circle one)

Child's Birthdate: _____/_____/_____ Child's Age: _____

School: _____ Grade: _____

Child's Home Phone #: (____) _____ SS#: _____

Child's Home Address: _____

_____

Child's Previous/Present Dentist: _____

Last Visit Date: _____

2 Who is Accompanying the Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Whom may we thank for referring you? _____

Other family members seen by us: _____

_____

Parent's Marital Status: Single Married Widowed Divorced Separated (circle one)

3 Parents' Information

❑ Mother ❑ Stepmother ❑ Guardian

Name: _____ Birthdate: ____/____/____

Work # (____) _____ Ext. ____ Home #: (____) _____

Employer: _____

SS#: _____ Cell #: (____) _____

Email Address: _____

❑ Father ❑ Stepfather ❑ Guardian

Name: _____ Birthdate: ____/____/____

Work # (____) _____ Ext. ____ Home #: (____) _____

Employer: _____

SS#: _____ Cell #: (____) _____

Email Address: _____

4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____

Work # (____) _____ Ext. ____ Home #: (____) _____

Employer: _____

SS#: _____ Cell #: (____) _____

Email Address: _____

5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ ID#: _____

Policy Owner's Employer: _____

Orthodontic Coverage? Yes No (circle one)

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ ID#: _____

Policy Owner's Employer: _____

Orthodontic Coverage? Yes No (circle one)

6 Has the Child Ever Had the Following Medical Problems?

Y N Asthma/Respiratory Impairment
Y N Bronchitis
Y N Pneumonia
Y N Sleep Apnea
Y N Large Tonsils

Y N ADD or ADDHD
Y N Behavioral Disorder
Y N Severe Anxiety
Y N Autism
Y N Developmental Delay
Y N Hearing Impairment
Y N Handicaps/Disabilities
Y N Convulsions/Epilepsy

Y N Abnormal Bleeding
Y N Blood Transfusions
Y N Hemophilia
Y N Sickle Cell Anemia
Y N Heart Murmur
Y N Congenital Heart Defect
Y N HIV/AIDS
Y N Hepatitis
Y N Diabetes
Y N Cancer
Y N Tuberculosis (TB)
Y N Kidney/Liver Problems
Y N Rheumatic/Scarlet Fever

Y N Allergies to any drugs
Y N Any hospital stays
Y N Any operations
Y N Family history of bad reactoins to anesthesia (local or general)

Please discuss any medical problems that the child has had:

_____

_____

_____

_____

Is the child currently under the care of a physician? Yes No (circle one)

Child's Physician: _____

Physician's Ph #: (_____)_____ Last Visit Date: ____/____/____

Describe the child's current health: Good Fair Poor (circle one)

Please list all the drugs the child is currently taking: _____

_____

_____

Please list all the drugs the child is allergic to: _____

_____

_____

7 Why did you bring the child to the dentist today?

_____

_____

Has the child ever had a serious/difficult problem associated with previous dental work? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No

Is the child taking fluoridated suplements? ❑ Yes ❑ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Does the child brush his/her teeth daily? ❑ Yes ❑ No

8 Does your child have any of the following habits?

Nursing Bottle Habits ❑ Yes ❑ No

Thumb/Finger Sucking ❑ Yes ❑ No

Tongue Thrust ❑ Yes ❑ No

9

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

I understand that the information that I have given is correct and, to the best of my knowledge, that it will be held in the strictest of 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 Date

The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.