Kids First
PEDIATRIC DENTISTRY

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WE KNOW HOW TO MAKE KIDS SMILE!

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Patient Information

Date: _____

Patient Last Name: _____ First Name: _____ Nickname: _____

Patient DOB: _____ Patient Age: _____ SS#: _____ Male _____ Female_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Mom Cell: _____ Dad Cell: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Address: _____ Relationship: _____

How did you find out about our office? _____ (Patient name or referral source)

Parents: _____Married _____Single _____Separated _____Divorced _____Widowed

Custodial Parent/Grandparent: (If applicable) _____

Father's Name: _____ SS#: _____ DOB: _____

Mother's Name: _____ SS#: _____ DOB: _____

Mother's Employer: _____ Father's Employer: _____

Mother's Work Number: _____ Father's Work Number: _____

Dental Insurance Company: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Address (If different from above) _____

ID Number: _____ Group Number: _____

Insurance Company Phone Number: _____

Medical History

PCP Name: _____ Address: _____ Phone: _____

Date of last physical examination: _____

Is a physician treating your child for a specific illness? ____Yes ____No; If so, for what reason? _____

Is your child currently on any medications? ____Yes ____No

Drug	Dose	Frequency	Reason

Has your child shown any allergies or unusual reactions to the following?

Medications_____ Foods_____ Other_____

Has your child ever been hospitalized? _____Yes _____No; If so, when and for what reason? _____

Are there any psychological or emotional problems you would like to bring to our attention? _____Yes _____No

Does your child have any of the following diseases or conditions? (Please circle)

Accidents or severe infections	Chicken Pox	Liver problems, Jaundice or Hepatitis
AIDS or AIDS related symptoms, HIV	Convulsion, Seizures or Epilepsy	Malignancies
Anemia or Blood Disorders	Diabetes	Mental Retardation
Asthma or Lung Problems	Fainting	Muscular
Autism/Autism Spectrum Disorder	Hearing	Sickle Cell Anemia
Bleeding Problems	Headache	Sinus
Blood Transfusion	Heart Murmur, Congenial Heart Disease	Speech or Learning Disorder
Cancer/Tumor	Hyperactivity ADHD	Vision Problems
Cerebral Palsy	Kidney or Bladder Problems	Other, if so, explain _____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information the Dentist should be aware of or that has not been covered above.

_____

Dental History

Is this your child's first visit to a dentist? _____Yes _____No; If not, how long since the last dental visit? _____
Child's previous dentist: _____ Address: _____
Has your child ever has any unpleasant dental experiences? _____

Does your child brush his/her own teeth? _____Yes _____No; How frequently and when? _____

Do you brush your child's teeth? _____Yes _____No; How frequently and when? _____

Does your child floss? _____Yes _____No

Does your child have any of the following habits? (Indicate ages when occurred)

Bottle at night __Yes __No	Use a pacifier __Yes __No	Thumb or finger sucking __Yes __No
Lip sucking or biting __Yes __No	Mouth Breathing __Yes __No	Grinds Teeth __Yes __No

Has your child had fluoride in any of the following forms?

Fluoride tablets or in multivitamins __Yes __No __Not Sure

Drinking Water (community fluoridation) __Yes __No __Not Sure

Topical Application on teeth (please circle) Dentist Applied Home Rinse Home Brush on gel School Rinse

Have your child's teeth ever been injured? __Yes __No; When? _____ Cause? _____

Does your child tend to complain of clicking, popping and crunching noises in his/her ears while chewing? __Yes __No

I certify that I have read and understand the information I have filled out on this form to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to the health of my child. I also authorize the completion of all mutually agreed upon dental services.

Signature **Relationship** **Date**