Dentistry 4 Kidz

.....TO BE COMPLETED BY THE PERSON AUTHORIZED TO TAKE DECISIONS REGARDING DENTAL TREATMENT FOR THIS MINOR.....

** DATE_____

1. Tell us about your child:

Name:_____
Last First M. I.
Nickname_____ Female or Male
Age_____ Birthdate_____
Interests:_____

Physical/ Mailing Address:

_____
_____
Tel #: Home:_____
Mobile_____
Mobile:_____
E-mail:_____

1. Family Information:

Father's Name_____
Biological Parent/ Stepfather / Legal Guardian (Please Circle)
DOB:_____SS #:_____
Employer_____
Work #:_____

Mother's Name_____
Biological Parent/ Stepmother/ Legal Guardian (Please Circle)
DOB_____ SS #:_____
Employer_____
Work #:_____
Marital Status of Parents_____
*Is the child adopted? Yes or No * If Yes, Please give details:_____
_____
*Is the child aware of been adopted? Yes or No
Who has legal custody of this child? Adoptive Parents/
Other: Explain_____
_____

Emergency Contact: Name/ Tel #:_____
_____
_____

3. Concerns Regarding Your child's teeth:

Date/Place of Last Dental Exam:_____
Were X-rays Taken? Yes or No
Injuries to the teeth face or mouth in the past? Yes or No
Please explain_____
_____
_____

Habits: Yes or No: (Thumb sucking for example)
If Yes, please explain:_____
_____

Updated_____

4. Health History:

ALLERGIES:_____
_____

(Please circle) How would you describe the child's overall health?
Excellent Good Poor
*Is the child under Medical Treatment? If yes, Please explain:
_____
_____

Has the child ever had any of the following conditions?

Y N	Abnormal Bleeding	Y N	Handicaps/Disability
Y N	Allergies to any Drug	Y N	Hearing Impairment
Y N	Any Hospital Stay	Y N	Heart Murmur
Y N	Any Operations	Y N	Hemophilia
Y N	Asthma	Y N	Hepatitis
Y N	AUTISM	Y N	HIV+/ AIDS
Y N	ADD/ ADHD	Y N	Kidney/Liver Condition
Y N	Congenital Heart Problem	Y N	Radiation treatment
Y N	Convulsions/Epilepsy	Y N	Rheumatic fever
Y N	Cancer/ Chemotherapy	Y N	ALLERGY TO LATEX
Y N	Handicap/ Disability	Other Medical Condition	

Please explain details/ dates:
_____
_____
_____

Is your child on any kind of therapy? Explain:_____
_____
_____

Please list Medications the child is Taking:
_____ _____
_____ _____
_____ _____

Have you been told that the child should take Antibiotics Before Dental Treatment? Yes or No

Please list Medications that Child is Allergic to:
_____ _____
_____ _____
_____ _____
Child's weight:_____lbs/ kg

Name of Pediatrician_____
***Telephone #_____

5. Insurance Information: Complete!!!!

DEROS_____
Insurance Co. Name_____
Tel #:_____
Policy Owner's Name_____
SS# or Policy Number_____
Employer_____