Tell Us About Your Child

Today's Date:____________

Child's Name:_______________________________________
Last First M

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

Nickname:________________________ Male: ☐ Female: ☐

School:_____________________ Grade:____________

Hobbies:____________________________________

Child's Home #: (_____)___________S.S.#:______________

Child's Home Address: ________________________________
Apt. #

____
City State Zip

General Information

Who is accompanying the child today?

Name:______________________ Relationship:____________

Do you have legal custody of this child? Yes: ☐ No: ☐

Previous Dentist:______________ Last Visit Date:__________

Dentist Phone #:(_____)__________________

Emergency Contact Information:

Name:_______________ Relationship to Patient:____________

Phone Number: (_____)_________________

Address: ____
Apt. #

____
City State Zip

Parent Information

Person Responsible for Account:__________________ Parents Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

☐ **Father** ☐ **Step Father** ☐ **Guardian**

Name:_________________________ Birthdate:____________

Address (if different than child's) Home #:(____)____________

____

____

S.S.#: ___________________ D.L.#______________________

Work #:(____)______________ Cell/other #:(____)___________

Email:____

Employer:____

Employer's Address:___________________________________

____
City State Zip

***If you have Dental Insurance for the Child please fill out below:**

Primary Insurance Co. Name:__________________________

Insurance Address:____________________________________

____
City State Zip

Insurance Phone #: (____)______________________________

Group ID# (Plan, Local, or Policy #):____________________

☐ **Mother** ☐ **Step Mother** ☐ **Guardian**

Name:_________________________ Birthdate:____________

Address (if different than child's) Home#:(___)____________

____

____

S.S.#: ___________________ D.L.#______________________

Work #:(____)______________ Cell/other #:(____)___________

Email:____

Employer:____

Employer's Address:___________________________________

____
City State Zip

***If you have Dental Insurance for the Child please fill out below**:

Primary Insurance Co. Name:__________________________

Insurance Address:____________________________________

____
City State Zip

Insurance Phone #: (____)______________________________

Group ID# (Plan, Local, or Policy #):____________________

Secondary Insurance

Insurance Co. Name:_____________________________ Insurance Address:_____________________________________

Insurance Phone #:(_____)__________________ Group ID#:______________________________

Dental History

Reason for your dental visit today?:____________________________

____

____

Is the child currently in pain? Yes ☐ No ☐

Does the child require antibiotics before dental treatment? Yes ☐ No ☐

Is the child's water Fluoridated? Yes ☐ No ☐

Is the child taking Fluoride Supplements? Yes ☐ No ☐

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

Does the child brush his or her teeth daily? Yes ☐ No ☐

Does the child floss his or her teeth daily? Yes ☐ No ☐

Is the child currently under the care of a physician? Yes ☐ No ☐

Child's Physician:____

Phone #:(_____)_________________ Date of last visit:___________

Describe the child's current physical health: Good ☐ Fair ☐ Poor ☐

Please list all prescriptions/ OTC or herbal supplement drugs that the child is currently taking:____________________________________

____

List all child's allergies (including medications):_________________

____

Latex allergy? Yes ☐ No ☐ Penicillin allergy? Yes ☐ No ☐

Medical History

Y	N	Abnormal Bleeding	Y	N	Heart Murmur
Y	N	ADD/ ADHD	Y	N	Hepatitis
Y	N	Aids/ HIV	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	Hives
Y	N	Hospital stays/ Operations	Y	N	Kidney Problems
Y	N	Artificial bones/Joints/Valves	Y	N	Liver Problems
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Cancer	Y	N	Lupus
Y	N	Chicken Pox	Y	N	Measles
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Convulsions	Y	N	Mononucleosis
Y	N	Diabetes	Y	N	Prosthetics
Y	N	Epilepsy	Y	N	Rheumatic Fever
Y	N	Exposed to HIV but Neg(-)	Y	N	Scarlet Fever
Y	N	Handicapped/Disabilities	Y	N	Skin Rash
Y	N	Hearing Impairment	Y	N	Tuberculosis

Are the child's immunizations current? Yes ☐ No ☐

Please list any other serious medical problems the child experiences:_

____

Does/Did the child experience any of the following?

Y	N	Breast fed	Y	N	Nursing Bottle Habits
Y	N	Clenching/ Grinding teeth	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumbsucking
Y	N	Tongue Thrusting	Y	N	Used Pacifier

Our office is HIPAA compliant and is committed to meeting or exceeding the standard 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 my need. My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA).

Print:______________________________ Signature: _________________________________ Date:__________________

Release

•I authorize St. George Kids Dental to release any information including the diagnosis and the records of any treatment or examination rendered to my child/children during the periods of such dental care to third party payers and/or other health practitioners. • I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. • I authorize and request St. George Kids Dental to use "Signature on File" for my signature on all dental insurance forms to expedite computer processing of my claims. • I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment and/or copayment and/or deductible of all services rendered on mine or my dependents behalf.

Print:________________________________ Signature:__________________________________ Date:_________________

OFFICE USE ONLY

I have verbally reviewed the medical/ dental information above with the parent/guardian and patients named herein.

Staff signature: ____ Date:_________________________