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KindredSmiles

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

CHILD'S NAME: _____ Nick Name: _____ Date: _____
Last First Middle

Birthdate: _____ Age: _____ ☐ Male ☐ Female Home Phone #: _____

Address: _____
Street City State Zip

Sport/Hobbies: _____

List brothers / sisters with age:_____

Who is accompanying your child today? _____ Relation _____ Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you to our office? _____

PARENT INFORMATION

MOTHER'S INFORMATION: Mother ☐ Step Mother ☐ Guardian ☐ Other ☐ _____ Social Security #: _____-_____-_____

Name: _____ Birth date: _____ Email: _____
Last First Middle

Mailing Address: _____
Street City State Zip

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Employer Name and Address: _____ Occupation: _____

FATHER'S INFORMATION: Father ☐ Step Father ☐ Guardian ☐ Other ☐ _____ Social Security #: _____-_____-_____

Name: _____ Birth date: _____ Email: _____
Last First Middle

Mailing Address:_____
Street City State Zip

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Employer Name and Address: _____ Occupation: _____

Parents Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Person responsible for account: _____ Relation to patient: _____

Mailing Address: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____Email: _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE ***Insured's Name:*** _____ Birth date: _____

Insurance Company Name: _____Group #: _____ ID #: _____

Insurance Co. Address: _____Phone #: _____

Do you have dual coverage? Yes_____ No _____

SECONDARY DENTAL INSURANCE ***Insured's Name:*** _____Birth date: _____

Insurance Company Name: _____Group #:_____ ID #:_____

Insurance Co. Address: _____ Phone #: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone #: _____ Relation to Patient: _____

MEDICAL HISTORY

PHYSICIAN: _____ Date of Last Visit: _____
Address: _____ Phone #: _____

ALLERGIES:

Yes No Is your child allergic to any latex, metals, nickel or plastics? *Please list:*_____
Yes No Is your child allergic to any medication / things? *Please list:* _____

Has your child ever had any of the medical conditions listed below: Yes _____ No _____ *If yes, please circle:*

Abnormal Bleeding	Bone Disorders	Gastrointestinal Disorders	High/Low Blood Pressure	Psychiatric Problems
ADD or ADHD	Cancer/Tumor	Hearing Impairment	HIV/AIDS	Radiation/Chemotherapy
Anemia	Congenital Heart Defect	Heart Problems/Murmur	Kidney Problems	Rheumatic Fever
Artificial Bones/Joints/Valves	Diabetes	Hemophilia	Nervous Disorders	Severe/Frequent Headache
Asthma	Dizziness	Hepatitis/Liver Problems	Pneumonia	Sinus Problems
Autism	Epilepsy/Seizures	Herpes/Fever Blisters	Prolonged Bleeding	Tuberculosis

Is your child taking any medication? *Please list:* _____
Is there a history of a major illness? *Please list:*_____
Has your child had any operations or been involved in a serious accident? *Please list:* _____
Are there any handicaps/disabilities that we should be aware of? _____
Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

Is this your child's first dental visit: Yes No Has your child been to see a Dentist previously? Yes No
If yes: GENERAL DENTIST:_____ Date of Last Visit/Reason: _____

Yes No Is your child presently in any dental pain?_____
What concerns you most about your child's teeth? _____

Has your child ever had any of the habits listed below: Yes _____ No _____ *If yes, please circle:*

Clenching Teeth	Thumb / Finger Habit	Lip Sucking	Mouth Breathing	Nail Biting
Grinding Teeth	Tongue Thrust	Lip Biting	Speech Problems	Bottle Habit

Yes No Has your child ever experienced any unfavorable reaction to dentistry?_____
Yes No Is any part of your child's mouth sensitive to temperature or pressure? Where? _____
Yes No Have there been any injuries to face, mouth, or teeth?_____
Yes No Has your child been informed of any missing or extra teeth? _____
Yes No Has your child ever lost or chipped any permanent teeth? _____
Yes No Does your child ever experience jaw clicking or popping? _____
Yes No Does your child experience "tension" headaches? _____
Yes No Does your child brush daily? _____
Yes No Does your child use fluoride toothpaste?_____
Yes No Do gums bleed when brushing? _____
Yes No Is your child presently on a special diet?_____
Yes No Is your child pregnant? _____
Yes No Does your child or have they ever used tobacco?_____

I have truthfully answered all the above questions and agree to inform this office of any changes in my child's medical or dental history. I understand that diagnostic records may be used for educational and promotional purposes. In addition, I authorize Kindred Smiles Pediatric Dentistry and staff to perform the necessary dental services my child needs.

I understand that I am responsible for payment of services rendered and also for paying any co-payments and deductibles that my insurance does not cover. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

This office reserves the right to verify the credit status of patients and/or their parents prior to extending credit for dental fees and may, at the discretion of the office, use the services of credit reporting services.

Parent/Guardian Signature: _____ *Date*: _____

Doctor Signature: _____ *Date*: _____