Kids Plus Pediatric Dentistry, P.C.

DEMOGRAPHIC INFORMATION

Name of Child_____Date_____
Date of Birth_____Age_____Sex_____
Home Address_____
Street City State Zip code
Home Phone_____
School_____Grade_____
Names and *ages* of other children in family_____
Parent/Guardian_____ Married Single Other_____
How do you wish to be addressed?_____
Cell Phone_____Email_____
Employer_____Work Phone_____
How do you prefer to be contacted? Home Cell Work
Parent/Guardian_____Married Single Other_____
How do you wish to be addressed?_____
Cell Phone_____Email_____
Employer_____Work Phone_____
How do you prefer to be contacted? Home Cell Work
Who has legal custody of patient?_____
Person responsible for account_____SS#_____DOB_____
Dental Insurance Co._____Group #_____
Whom may we thank for referring you to us?_____
What is the reason for your child's dental visit?_____

HEALTH HISTORY

□ YES □ NO Is your child in good health?
Name of Pediatrician_____Clinic/Hospital_____
Pediatrician Phone_____Date of last exam_____
□ YES □ NO Has your child ever had a health problem? _____
□ YES □ NO Has your child ever been hospitalized? Please give reasons and dates_____
□ YES □ NO Is your child allergic to anything? _____
□ YES □ NO Is your child currently taking any medications? Please give medication, dose, and reason_____

Please circle if your child has been treated for any of the following:

Heart disease	Bleeding/transfusions	Asthma/breathing
Liver/GI disease	Anemia	Diabetes
Kidney disease	Rheumatic fever	AIDS/HIV
Speech/hearing	Seizures	Hepatitis
Cerebral palsy	Cleft lip/palate	Blood dyscrasias
Cancer/tumors	Congenital birth defects	Mental delays
Physical delays	Autism	Personality/social
Recurrent headaches	Frequent infections	Adverse drug rxn
Eyesight	Significant injuries	Endocrine/growth

Please elaborate on any items circled:_____
_____
_____

Do you consider your child to be □ advanced in the learning process
□ progressing normally
□ slow in the learning process

Was your child □ breast fed □ bottle fed At what age stopped?_____

DENTAL HISTORY

□ YES □ NO Has your child ever been to the dentist? Name of dentist and date _____

□ YES □ NO Has your child experienced any unfavorable reaction from previous dental care? Explain_____

□ YES □ NO Does your child suck a finger, thumb or pacifier?

□ YES □ NO Does your child have pain with chewing, yawning or wide opening?

□ YES □ NO Does your child's jaw make noise and is pain associated with the sounds?

Please check if your child is having problems with any of the following:

□ Cavities □ Toothache □ Teeth Sensitive
□ Trauma □ Gum Infections □ Color of Teeth
□ Orthodontics □ Jaw Sounds □ Other

Comments:_____
_____
_____
_____

FLUORIDE HISTORY

□ YES □ NO Is your home water supply fluoridated?

□ YES □ NO Does your child use a fluoridated toothpaste?

□ YES □ NO Do you give your child another form of fluoride? What? _____

□ YES □ NO Does your child participate in a school fluoride rinse program?

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Fisher/Dr. Kitley/Dr.Johnson to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Fisher/Dr. Kitley/Dr.Johnson to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Fisher/Dr.Kitley/Dr.Johnson will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature_____**Date**_____

Providers Signature_____**Date**_____