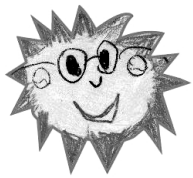
DUNES DENTAL 4 Kids



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Tell Us About Your Child

Today's Date:_____ Best Phone # to Reach You at:_____ ☐Mobile ☐Home ☐Work

Child's Name:_____ ___ _____ Child's Birthdate:_____Child's Age:_____
First M.I. Last

Nickname:_____ ☐Male ☐Female School:_____ Grade:_____

Child's Home Address:_____
City State Zip

What patient or physician can we thank for referring you? _____

Parent's Information

Parent's Marital Status: ☐Married ☐Divorced ☐Separated ☐Widowed ☐Remarried ☐Single ☐Partnered

Mother Name:_____ ___ _____ Social Security #:_____
First M.I. Last

Birthdate:_____ E-mail Address:_____

Address:_____
City State Zip

Employer:_____

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

Father Name:_____ ___ _____ Social Security #:_____
First M.I. Last

Birthdate:_____ E-mail Address:_____

Address:_____
City State Zip

Employer:_____

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

Insurance Information

Primary Insurance Dental Coverage? ☐Yes ☐No

Insured's Name:_____ ___ _____ Relationship to Patient:_____
First M.I. Last

Insured's Birthdate:_____ Insured's ID #:_____ Insured's Employer:_____

Employer's Address:_____

Insurance Co. Name:_____ Phone #:_____ Group # (Plan, Local or Policy #):_____

Insurance Co. Address:_____

Secondary Insurance Dental Coverage? ☐Yes ☐No

Insured's Name:_____ ___ _____ Relationship to Patient:_____
First M.I. Last

Insured's Birthdate:_____ Insured's ID #:_____ Insured's Employer:_____

Employer's Address:_____

Insurance Co. Name:_____ Phone #:_____ Group # (Plan, Local or Policy #):_____

Insurance Co. Address:_____

Dental History

Is the child currently in pain? ☐Yes ☐No What is the primary reason for today's visit?_____

Has the child experienced problems with previous dental work? ☐Yes ☐No

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

Floss his/her teeth daily? ☐Yes ☐No

Has the child had sealants in the past? ☐Yes ☐No

What is the date of the last dental xray?:

☐Previous ☐Present Dentist:_____ Date of Last Visit:_____

Why did you leave your previous dentist?:_____

What did you like most about any dentist you have seen?:_____

What did you dislike about any dentist you have seen?:_____

How do you think your child will do today?:_____

Does/did the child have any of the following habits?

☐Yes ☐No Lip Sucking/Biting
☐Yes ☐No Mouth Breather
☐Yes ☐No Used Pacifier
☐Yes ☐No Nursing Bottle Habits

☐Yes ☐No Clenching/Grinding Teeth
☐Yes ☐No Nail Biting
☐Yes ☐No Speech Problems
☐Yes ☐No Tongue Thrust

☐Yes ☐No Tongue/Cheek Biting
☐Yes ☐No Thumb/Finger Sucking
☐Yes ☐No Chewing on Objects
☐Yes ☐No Breast Fed

Medical History

Child's Physician:_____ Phone #:_____ Date of Last Visit:_____

Address:_____

Is the child currently under the care of a physician? ☐Yes ☐No Please explain:_____

Please describe the child's current physical health: ☐Good ☐Fair ☐Poor ***Are immunizations current?*** ☐Yes ☐No

Please list all of the drugs that the child is currently taking:_____

Is your child allergic to any of the following: ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Nut Allergy

Does your child have any medical conditions that require Pre-Med? Yes No

Has the child had/experienced any of the following:

☐Yes ☐No Abnormal Bleeding
☐Yes ☐No Anemia
☐Yes ☐No Any Hospital Stay/Operations
☐Yes ☐No Asthma
☐Yes ☐No Autism Spectrum
☐Yes ☐No Birth Defects
☐Yes ☐No Blood Transfusions
☐Yes ☐No Cancer
☐Yes ☐No Cerebral Palsy
☐Yes ☐No Chronic Ear Infections/Tubes
☐Yes ☐No Cystic Fibrosis
☐Yes ☐No Delayed Speech Development
☐Yes ☐No Developmental Delay
☐Yes ☐No Diabetes
☐Yes ☐No Down Syndrome
☐Yes ☐No Emotional/Psychiatric Problems
☐Yes ☐No Epilepsy
☐Yes ☐No Food Allergies
☐Yes ☐No G-Tube Feeding
☐Yes ☐No Hearing Loss/Impairment
☐Yes ☐No Heart Condition/Murmur
☐Yes ☐No Hepatitis
☐Yes ☐No HIV/AIDS
☐Yes ☐No Hyperactivity/ADHD
☐Yes ☐No Kidney Disease
☐Yes ☐No Learning Disabilities
☐Yes ☐No Liver Disease
☐Yes ☐No Muscular Dystrophy
☐Yes ☐No Radiation Therapy
☐Yes ☐No Rheumatic Fever
☐Yes ☐No Seizures
☐Yes ☐No Seasonal Allergies
☐Yes ☐No Sickle Cell Anemia
☐Yes ☐No Skin Disorders
☐Yes ☐No Sleep Apnea/Snoring
☐Yes ☐No Spina Bifida
☐Yes ☐No Tonsillitis
☐Yes ☐No Tuberculosis (TB)
☐Yes ☐No Tumors
☐Yes ☐No Syndrome (specify)

Please explain any Yes answers:_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that 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 services that my child may need. I assign the Doctor to all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature:_____ Date:_____