KID'S DENTISTREE

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Demographic Information

Patient____ Date________________
Name child would like to be called____
Birthday________________ Sex___________ Home Phone___________________
Home Address____
street *town* *zip code*
Names *and ages* of other children in family______________________________
School____ Grade _______________

Mother_______________________________________E-mail____________________
Mother's SS#__________________________________ DOB______________________
Mother's Address______________________________Cell Phone________________
Mother's Employer_____________________________Work Phone________________
Father_______________________________________E-mail____________________
Father's SS#__________________________________DOB ______________________
Father's Address______________________________Cell Phone________________
Father's Employer_____________________________Work phone________________
Who has legal custody of patient?____
Person responsible for payment of account_____________________________________

Dental Insurance: ☐ Yes ☐ No Subscriber's Name_________________________
Employer ______________________ Insurance Company_________________________
Claims Address ____
Insurance phone ________________ Group No__________________________________
Secondary Dental Insurance: ☐ Yes ☐ No Subscriber's Name ______________________
Employer_______________________ Insurance Company________________________
Claims Address ____
Insurance phone ________________ Group No__________________________________

Whom may we thank for referring you to us?____________________________________

What is the reason for your child's dental visit?__________________________________

Health History

Patient____Date___________________

☐ Yes ☐ No Is your child in good health?

☐ Yes ☐ No Are your child's vaccinations up to date?

☐ Yes ☐ No Has your child ever had a health problem?__________________________

☐ Yes ☐ No Has your child ever been hospitalized? Please give reason and dates_______

____

☐ Yes ☐ No Is your child allergic to any medicines/food/substances? _______________

____

☐ Yes ☐ No Is your child currently taking any medications? Please give medication and reason____

☐ Yes ☐ No Has your child received general anesthesia/sedation?

☐ Yes ☐ No Has your child ever received a blood transfusion?

☐ Yes ☐ No Were there any problems at birth?_______________________________

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

☐ Heart disease/murmur	☐ Eye problems	☐ Kidney disease	☐ ADD/ADHD
☐ Bleeding/transfusions	☐ Speech/hearing	☐ Diabetes	☐ Autism Spectrum Disorder
☐ Sickle cell anemia	☐ Ear infections	☐ Thyroid Problems	☐ Brain injury
☐ Anemia	☐ Asthma	☐ Cerebral palsy	☐ Mental delays
☐ Hepatitis	☐ Mouth breathing	☐ Seizures	☐ Physical delays
☐ HIV/AIDS	☐ Snoring	☐ Spina Bifida	☐ Social delays
☐ Rheumatic fever	☐ Cleft lip/palate	☐ Liver/GI disease	☐ Congenital birth defects
☐ Leukemia/cancer	☐ Tuberculosis	☐ Orthopedic problems	☐ Other problems

Please elaborate on any items checked:____

____

____

Name of Pediatrician ______________________________Last physical exam__________

Name of Pediatric Specialists (if applicable) ______________________________________

☐ Yes ☐ No If necessary, may we consult with these physicians?

Dental History

Patient____Date____________________

☐ 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 Do you assist your child with toothbrushing? How many times/day ________

☐ Yes ☐ No Do you assist your child with flossing? How many times/week ____________

☐ 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?

Was your child ☐ breast fed ☐ bottle fed At what age was it stopped?_______________

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 Does your child use a fluoride toothpaste?

☐ Yes ☐ No Do you give your child any other form of fluoride? What?_______________

Signature____ Date ___________________

Dentist Signature _______________________________________ Date ___________________

Consent for Treatment and Billing

I give permission to **Kid's Dentistree, PLLC** to provide dental, counseling and educational services as well as any treatment related to those services to myself or the minor child named below.

Kid's Dentistree, PLLC shall have the sole discretion to decide which person (employee or individual contractor) shall give such treatment. I understand the service and treatment listed above do not involve exact science and the results are not always known or guaranteed.

I understand that testing for blood borne disease (including HIV/AIDS) may be preformed upon a patient without separate written consent in the event that a health care professional or employee of **Kid's Dentistree, PLLC** sustain a percutaneous, mucous membrane, open wound or occupational exposure to blood or bodily fluids.

I give my permission to **Kid's Dentistree, PLLC** to bill my insurance carrier and if request provide any medical information to them. I also give my permission use my x-rays and photographs for display.

As a condition of your treatment by this office, financial arrangement must be made in advance. All emergency dental services or dental services performed without previous financial arrangements must be paid for at the time services are rendered. Please review our financial policy for our convenient payment methods that we offer.

As a courtesy to you we will file claims to your insurance carrier and assist in collecting. However, the balance on your account after filing is your responsibility regardless of your carrier's said coverage.

A service charge of 1 ½% per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 60 days unless previously written arrangements are satisfied.

As a courtesy to our office and to offer better patient care, we reserve the right to charge a $25.00 cancellation fee if we do not receive a 24 hour notice for appointment changes/cancellations.

I have read and understood the above conditions of treatment and billing and agree to their content. I sign it freely and voluntarily.

Date ____________________

Authorized Representative of Minor(s) ____

Relationship to Minor(s) ____

1)__________________________	2)__________________________	3)__________________________
Minor Child's Full Name	Minor Child's Full Name	Minor Child's Full Name
4)__________________________	5)__________________________	6)__________________________
Minor Child's Full Name	Minor Child's Full Name	Minor Child's Full Name