PATIENT HISTORY

Tell us about your child:

Patient's Name: ______________________________ Age: __________ DOB: ____________Social #: _________-_______-_________
Nickname: __________________________ Hobbies: ____ Male Female
Physical Address: ____
Physical Address: ____
Home phone: (________) __________-_____________ School: ____

Father's Information: Married Single Guardian Step-father Foster parent

Name: ____ DOB: ____________Social #: _________-_______-_________
Employer: ____ Work phone: (________) __________-______________
Driver's license: ____ Expires: ____
Home phone: (________) __________-_____________ Cell phone: (________) __________-______________

Mother's Information: Married Single Guardian Step-mother Foster parent

Name: ____ DOB: ____________Social #: _________-_______-_________
Employer: ____ Work phone: (________) __________-______________
Driver's license: ____ Expires: ____
Home phone: (________) __________-_____________ Cell phone: (________) __________-______________

Who is accompanying the child today?

Name: ____ Relation: ____

Contact Email: ______________________________________ Do you have legal custody of this child? YES NO

In case of emergency please call:

Name: ____ Phone: (________) __________-______________
Other family member seen by us: ____
Name of nearest relative not living with you: _________________________________ Phone: (________) __________-_____________

Person responsible for account:

Name: ____ Relation: ____
Home: (______) ________-_____________ Work: (______) ________-_____________ Cell: (______) ________-______________

Who may we thank for referring you?

Name: ____ Phone: (________) __________-______________
Address: ____

Insurance Information: We are not in-network

Insured's name: ____ Insured's DOB: __________________________
Insured's Social #: _________-_______-_________ Relationship to patient: ____
Insured's Employer: __________________________ Employer's address: ____
Employer's Phone: (______) ________-_____________ Insurance Company Phone: (______) ________-_____________
Insurance Company Name: ____
Insurance Company Address: ____

We are affiliated with the following insurance plans: Aetna, Ameritas, Assurant, Cinga, Guardian, Humana, and United Concordia, which means we would be considered an out-of-network provider with other insurance companies. Most dental insurance pay out-of-network benefits, but please verify that your policy will cover treatment by an out-of-network provider before you come in for your appointment. Payment of services is due in full at the time services are rendered. This includes all new patient evaluation appointments, prophylaxis (professional cleanings), emergency evaluations, re-care appointments, and treatment sum of $200.00 or less. We will submit and file claims with all insurances. It is your responsibility to give accurate insurance information so that this can be done in a timely manner.

____ ____________________________
Signature of parent/guardian Date

Child's Pediatrician: ______________________________ Pediatrician's Phone: (_____) _______-__________

Previous/Present Dentist: ____

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

Please describe your child's current physical health: Good Fair Poor

Please list all drugs that the child is allergic to: ______________________________

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Please list all drugs that the child is currently taking: ______________________________

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Does your child have any of the following habits?

Thumb/finger sucking	Nail biting	Mouth breathing
Lip sucking/biting	Nursing/bottle habits	Nighttime grinding of teeth

Does your child have a heart condition (such as a heart murmur)? Yes No

Explain if YES: ______________________________

If yes, child's cardiologist: ______________________________ Cardiologist's Phone: (_____) _______-__________

Does your child have (or ever had) any of the following medical problems?

YES	NO		YES	NO	
		Cancer			Hearing impairment
		Diabetes			Any operations
		Rheumatic Fever			Any hospital stays
		HIV+ / AIDS			Kidney/Liver problems
		Hemophilia			Handicaps/Disabilities
		Asthma			Allergies
		Hepatitis			Pregnant
		Tuberculosis (TB)			Smoker
		Chronic upper respiratory problems			ADD & ADHD
		Convulsions/Epilepsy			Developmentally delayed
		Abnormal bleeding			Autism/PDD-NOS

Please discuss any medical problems your child has had: ______________________________

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I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the doctors and the dental staff to perform any necessary dental services my child may need. The responsible party is the parent who brings the child to the dental office, independent of what a divorce decree may state. Reimbursement must be made between divorced parents. We will not intervene.

★ Only 1 custodial parent/caregiver will be allowed in the treatment room with the patient during treatment. Switching between custodial parents/caregivers will NOT be allowed because of distraction to the patient caused during transitions.

★ <u>VIDEO TAPING</u> in the office is <u>FORBIDDEN</u> unless formal consent form Kids N More Dentistry has been obtained prior to treatment. CELL PHONES should be turned off or on silent during any preventative or restorative treatment.

______________________________ ______________________

Signature of parent/guardian Date

______________________________ ______________________

Signature of person accompanying child Date