Welcome to our Practice!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PATIENT INFORMATION

Name _____ Nickname _____ Home Phone _____

Address _____

City _____ State _____ Zip _____ Child's Physician _____

Sex ❒ M ❒ F Age _____ Birth Date _____ Physician's Phone _____

Soc. Sec. # _____ School _____ Grade _____

PARENT/GUARDIAN INFORMATION

❒ Mother ❒ Stepmother ❒ Guardian

Name _____

E-mail _____

Work Phone _____

Cell Phone _____

Soc. Sec. # _____ Birth Date _____

Employer _____

Occupation _____

❒ Father ❒ Stepfather ❒ Guardian

Name _____

E-mail _____

Work Phone _____

Cell Phone _____

Soc. Sec. # _____ Birth Date _____

Employer _____

Occupation _____

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Soc. Sec. # _____

Insurance Company _____ Group # _____

Insurance Claims Address _____ City _____ State _____ Zip _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. If there is any change in my child's medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. **I understand that I am financially responsible for all charges whether or not paid by the insurance company.**

_____ Signature

_____ Date

Dakota Kids Dentistry

Health History

Has your child had any difficulty with previous visits?

Comments: _____

Has your child ever had any of the following:

Asthma	☐ yes	☐ no
Diabetes	☐ yes	☐ no
Seasonal Allergies (ie: Hayfever)	☐ yes	☐ no
Allergies (ie: medicines/food/other)	☐ yes	☐ no
Cancer/Hepatitis	☐ yes	☐ no
Cleft Lip/Palate	☐ yes	☐ no
HIV/AIDS	☐ yes	☐ no
Hemophilia	☐ yes	☐ no
Autism	☐ yes	☐ no
Rheumatic Fever	☐ yes	☐ no
Congenital Heart Defect	☐ yes	☐ no
Handicaps/Disabilities	☐ yes	☐ no
Convulsions/Epilepsy	☐ yes	☐ no
Tuberculosis	☐ yes	☐ no
Abnormal Bleeding	☐ yes	☐ no
MRSA (Methicillin-resistant Staphylococcus aureus)	☐ yes	☐ no
Heart Murmur	☐ yes	☐ no

Type _____

Please explain any medical problems that your child has or had: _____

Is your child being treated by a physician at this time?

If so, why? _____

Is your child allergic to anything: (medicine, food, other)?

If yes, what? _____

Is your child taking any medicines at this time?

If so, what? _____

How often does your child brush? _____

How often does your child floss? _____

Previous Dentist _____ When _____

Is your child's water fluoridated?	☐ yes	☐ no
Does your child take fluoride supplements?	☐ yes	☐ no
Does your child suck thumb/pacifier?	☐ yes	☐ no
Does your child bite/chew nails or hard objects?	☐ yes	☐ no

Dentist's Review

_____

_____

_____

_____

_____

_____

Date _____ Signed Dr. _____

We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits, which will help keep their smile beautiful for their lifetime. We invite parents to accompany children into the examination area for their first visit. However, as a general office policy, we prefer that parents wait in the waiting room if children have to come back for treatment.

_____ Signature

_____ Date

Dakota Kids Dentistry