Welcome

Please take a few minutes to fill out the questionnaire so we could best serve your needs.
Thank you very much for your attention.

Child's Name _____ Nickname _____
Last First MI

Date of Birth _____ Age _____ Sex _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Parent/Legal Guardian's Name _____

☐ I am not the legal guardian, but I have permission from the legal guardian to authorize Kid's Dental Castle to perform any dental care as needed.

Home Phone ( ) _____ Parent's Work Phone ( ) _____

Parent's Cell Phone ( ) _____ E-Mail _____

Primary Insurance (Leave Blank if no Dental Benefits)

Subscriber _____ Relationship _____

Date of Birth _____ SS Number _____

Address ((If Different) _____

City _____ State _____ Zip _____

Phone ( ) _____ Cell Phone ( ) _____

Insurance Company _____

Address _____ Phone ( ) _____

City _____ State _____ Zip _____

Group # _____ Subscriber # _____

Other dependents covered under this plan? YES NO

_____

Responsible Party Information

Name _____

Relationship _____

Date of Birth _____

Social Security Number _____

Address (If Different) _____

City _____ State _____ Zip _____

Phone ( ) _____

Cell Phone ( ) _____

Employer _____

Work Number ( ) _____

In Case of an emergency, Contact _____ ( ) _____
How did you hear about our office? _____

Informed Consent

I hereby authorize the dentist and staff at Kid's Dental Castle to perform diagnostic aids including x-rays, models and photographs as appropriate to make a thorough diagnosis of my child's dental needs.

I authorize my insurance company to pay the dentist(s) all insurance benefits otherwise payable to me for service rendered.

I authorize the use of this signature on all insurance submissions. I authorize the dentist(s) 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 my insurance. I understand that I will be charged 18% APR for any past due balances over 60 days.

_____ _____ _____ _____
Signature **Date** **Dentist's Signature** **Date**

Payment is due in full at time of treatment unless prior arrangements have been approved

Reason for Today's Visit _____

Is this your child's first visit to the dentist? Yes / No

If not, Former Dentist_____ Phone ( )_____

Address_____ Reason for leaving_____

Date of last dental care_____ Date of last X-Rays_____

Dental History

Does your child have any of the following?

Sensitivity to heat	Yes / No	Sores or growths in the mouth	Yes / No	Grinding teeth	Yes / No
Sensitivity to cold	Yes / No	Bad breath	Yes / No	Bleeding gums	Yes / No
Sensitivity to biting	Yes / No	Loose teeth/ Broken filling	Yes / No	TMJ Disorder	Yes / No
Sensitivity to sweet	Yes / No	Swelling in the face	Yes / No	Clicking Jaw	Yes / No

How often does your child brush? _____ How often does your child floss? _____

Is your child nervous towards previous dental treatment? If yes, describe _____

Do you have any particular concerns regarding your child's dental care _____

Has your child or any member of the family had orthodontic treatment (braces)? Yes / No

Does your child have any of the following habits? (Circle) **Suck thumb / finger** **Suck/ bite lip** **Pacifier**
Chew hard objects **Grind teeth** **Clench jaw**

Medical History

Physician's Name _____ **Date of Visit** _____

Was your child a patient in a hospital? Yes / No	Has your child ever had a serious illness or surgery? Yes / No
If so, describe _____	If so, describe _____
Is your child medical care now? Yes / No	Is your child allergic to any medicine, anesthetic or latex? Yes / No
Is your child taking any medications now? Yes / No	If so, describe _____
If so, describe _____	_____

Does your child have any or ever had any of the following conditions?

Heart Problems	Yes / No	Kidney Problems	Yes / No	Venereal Disease	Yes / No
Coronary Insufficiency	Yes / No	Hepatitis	Yes / No	AIDS/HIV	Yes / No
Coronary Occlusion	Yes / No	Jaundice	Yes / No	Thyroid Disease	Yes / No
High Blood Pressure	Yes / No	Liver Disease	Yes / No	Nervous Disorder	Yes / No
Arteriosclerosis	Yes / No	Tuberculosis	Yes / No	ADD/ ADHD	Yes / No
Stroke	Yes / No	Lung Problems	Yes / No	Autism	Yes / No
Heart Murmur	Yes / No	Persistent Cough	Yes / No	Seizures / Fainting Spells	Yes / No
Rheumatic Heart Disease	Yes / No	Emphysema	Yes / No	Epilepsy	Yes / No
Sickle Cell Disease	Yes / No	Sinus Problems	Yes / No	Cerebral Palsy	Yes / No
Bleeding Disorder	Yes / No	Stomach Ulcers	Yes / No	Mental Disability	Yes / No
Excessive Bleeding	Yes / No	Diabetes	Yes / No	Hearing Disability	Yes / No
Anemia	Yes / No	Inflammatory Rheumatism	Yes / No	Developmental Disability	Yes / No
Congenital Heart Disease	Yes / No	Arthritis	Yes / No	Cleft Lip / Palate	Yes / No
Penicillin Allergy	Yes / No	Asthma	Yes / No	Premature Birth	Yes / No
Latex Allergy	Yes / No	Hives / Rashes	Yes / No	How many weeks?	_____

Does your child have any conditions NOT mentioned above? If so, describe _____

Is there any information about your child we should be aware of? _____

Adolescent Women:

Are you pregnant now or think you might be? Yes / No If so, how many weeks/ months? _____

Are you nursing? Yes / No

Are you taking Oral Contraceptive? Yes / No

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous To my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/ or other dental practitioners.

_____ _____ _____

Name of Parent / Legal Guardian (Please Print) **Signature** **Date**

_____ _____ _____

Review Medical History/ Comments **Dentist Signature** **Date**