Alaska Dentistry for Kids, LLC
Welcomes You!

1389 Huffman Park, Suite 208, Anchorage, AK 99511
907-274-2525

We strive to make each of your child's visits pleasant and comfortable. Our goal is to set a foundation with children which will help them keep their teeth strong and beautiful for their lifetime.

YOUR CHILD

CHILD'S NAME _____ Nickname _____ Sex _____
Birthdate _____ Age _____ School? ❑ Home ❑ Private ❑ Public ❑ Grade
Siblings: Names and Ages _____

RESPONSIBLE PARTY

Name _____ Relationship _____
Address _____
City _____ State _____ Zip Code _____ Email _____

❑ ***Mother*** ❑ ***Stepmother*** ❑ ***Guardian***

Name _____ Social Security ID# _____
Home Phone _____ Work Phone _____ Cell _____
Employer _____ Occupation _____

❑ ***Father*** ❑ ***Stepfather*** ❑ ***Guardian***

Name _____ Social Security ID# _____
Home Phone _____ Work Phone _____ Cell _____
Employer _____ Occupation _____

Parent's Marital Status: ❑ ***Single*** ❑ ***Married*** ❑ ***Divorced*** ❑ ***Widowed*** ❑ ***Separated***

Primary Dental Insurance

Subscriber's Name _____ Relationship _____ Birthdate _____
Address of Subscriber if different from child's _____
_____
Insurance Company _____ Group# _____

Secondary Coverage

Subscriber's Name _____ Relationship _____ Birthdate _____
Address of Subscriber if different from child's _____
_____
Insurance Company _____ Group# _____

Whom may we thank for referring you to us? _____

Today's Date _____

More info on back >> >> >>

MEDICAL HISTORY

Has your child ever had any of the following: (Check Yes or No. If Yes, please explain)

Yes	*No*	*Condition*	*Explanation*
		Is your child taking any medication?	
		Allergies to medicine? If so, please list.	
		Allergies to food? If so, please list.	
		Latex allergy?	
		Does your child have asthma?	
		Immunizations up-to-date?	
		Has your child had an illness in the last month?	
		Has your child been exposed to any infectious illness?	
		Previous hospitalizations or surgeries?	
		Difficulty with anesthesia?	
		Seizures or convulsions?	
		Birth defects?	
		Serious illness?	
		Heart Disease/ Murmur/ Rheumatic Fever?	
		Diabetes?	
		Does your child require antibiotic premed prior to dental treatment?	
		Has your child had kidney or bladder problems?	
		Is your child emotionally, physically or mentally challenged?	
		Does your child bruise easily or experience bleeding problems?	
		Fainting spells, dizziness or breath holding spells?	
		Has your child ever been to the dentist before?	
		Has your child had difficulty accepting dental treatment?	
		Is your child taking fluoride supplement or using a topical fluoride?	
		Is your child still nursing?	
		Does your child still take the bottle?	
		Other?	

Child's Physician _____

Reason for child's visit today _____

Things we should know _____

Is there family history of:

Yes	*No*	*Condition*	*Family Relationship*
		Diabetes?	
		Any bleeding problems?	
		Neuromuscular problems?	
		Trouble with anesthesia?	
		Heart disease?	
		Other?	

AUTHORIZATION

I have reviewed this questionnaire and answered the questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate and safe dental treatment for my child, and I agree to notify the dentist of any changes in my child's health status. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. If at any time you experience a lapse in coverage or there is any portion of your bill unpaid by insurance, it remains your full responsibility.

I agree to be responsible for payment of all services rendered on behalf of my dependants.

Signature of Parent or Guardian _____ ***Date*** _____