kiddo dental
Pediatric Dentistry

Date: _____

PATIENT INFORMATION

Patient name: _____ D.O.B _____ Male / Female
Insured Parent SS #: _____Primary Email Address: _____
Home Address: _____ City: _____
State: _____ Zip Code: _____ Primary phone: _____

PATIENT HEALTH HISTORY

Date of last dental visit: _____ Reason for visit: _____
Has the patient ever had **ANY** of the following? (**Please check all that apply)**

- ☐ **ADD/ADHD**
- ☐ **AIDS**
- ☐ **Autism/ the Autism Spectrum**
- ☐ **Allergies (seasonal)**
- ☐ **Anemia**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Bad breath**
- ☐ **Blisters in the mouth**
- ☐ **Blood diseases**
- ☐ **Bronchitis**
- ☐ **Cancer or Chemo**
- ☐ **Diabetes**
- ☐ **Dizziness**
- ☐ **Downs Syndrome**
- ☐ **Epilepsy**
- ☐ **Excessive bleeding**
- ☐ **Excessive Fevers**
- ☐ **Fainting**
- ☐ **Glaucoma/Eye Disorders**
- ☐ **Headaches**
- ☐ **Head injuries**
- ☐ **Heart Murmur**
- ☐ **Heart problems**
- ☐ **Hepatitis**
- ☐ **Jaundice**
- ☐ **Kidney/Liver disease**
- ☐ **Lyme's Disease/Meningitis**
- ☐ **Malignant Hyperthermia**
- ☐ **Mental or Nervous disorders**
- ☐ **MRSA/Any Infectious Diseases**
- ☐ **Pregnancy**
- ☐ **Respiratory problems/RSV**
- ☐ **Rheumatic fever/Rheumatism**
- ☐ **Sinus problems**
- ☐ **Tuberculosis**
- ☐ **Tumors**
- ☐ **Ulcers**
- ☐ **Other: _____**

Medications Taken: (**List all that apply**) _____Medication Allergies_____
Has the patient ever had any complications following dental treatment? YES / NO
If yes, please explain: _____
Has the patient ever been admitted to a hospital or required emergency care? YES / NO
If yes, please explain: _____
Is the patient under the care of a medical physician YES / NO Last Visit: _____
If yes, please explain: _____
Name of patient's medical doctor: _____Phone #:_____

To the best of my knowledge, all the answers and information are true and correct. If there is any change in the patient's medical history, I will inform the office staff and the dentist at the next appointment. IF you have any changes with your Insurance plan, please call the office in advance to discuss your benefits and give the office new dental insurance information.

_____ _____
Signature of parent, guardian or patient if over 18 Date

Initials_____ I, hereby, give consent for my child to have an exam, a teeth cleaning, a fluoride treatment, and any or all necessary X-rays for diagnosis of treatment or/for preventative measures as set by AAPD guidelines. X-rays are sole property of Kiddo Dental.
(Consent shall remain in effect unless otherwise stated or revoked by parent or legal guardian)

(OVER PLEASE)

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PARENTS / GUARDIAN / RESPONSIBLE PARTY INFORMATION

Parent (Mother): _____D.O.B: _____Married / Single / Divorced
Social security#: _____ Email: _____
Mailing Address (if different from patient) _____ APT#_____
City: _____ State: _____ Zip code: _____
Home phone: _____Cell: _____Work#:_____Ext: _____
Employer: _____Occupation: _____

Parent (Father): _____D.O.B: _____Married / Single / Divorced
Social security#: _____ Email: _____
Mailing Address (if different from patient) _____ APT#_____
City: _____ State: _____ Zip code: _____
Home phone: _____Cell: _____Work#:_____Ext: _____
Employer: _____Occupation: _____

Dental Insurance YES / NO

INSURANCE INFORMATION

Name of Insurance: _____ Phone # _____
Subscriber name: _____D.O.B: _____
Social Security #: _____Member ID# _____
Group # _____Group plan name or employer: _____

REFERRAL INFORMATION

Whom my we thank for referring you to Kiddo Dental?
Another patient: _____ Another Office: _____
Other: _____ Internet website: _____
Our website/drove by/ yellow pages

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is ever any changes in the patient's health, I (Parent/guardian) will update the patient's medical history at the next appointment.

_____ _____
Signature of Parent/Guardian/Responsible Party Date