Kids First Dental Medical History

Child's Name: ______________________________ Day Time Phone: ____________________
Date of Birth: __________________ Sex: ___M ___F Siblings seen here: ____________________
Home Address: ______________________ City: ______________ State: _____ Zip: __________
Email Address: ____
Child's Physician: _________________________ Phone #: ___________________________
Physician Address: ____
Is the child currently being treated for any condition? __Y __N Please explain: ________________________

Does your child have any allergies to the following?
☐ Pollen ☐ Latex ☐ Dust ☐ Food ☐ Food Dye ☐ Other: Please explain
____

List all medication the child is currently taking: ____
List any medication(s) that cause the child allergic reactions: ______________________________

Please check any that pertain to your child

☐ Abnormal Bleeding
☐ Aids/HIV*
☐ Anemia
☐ Attention Deficit Disorder/ADHD
☐ Asthma
☐ Autism
☐ Any hospital stay/surgery
☐ **ANY HEART CONDITION** *
☐ Blood Transfusion*
☐ Cancer
☐ Cerebral Disorders
☐ Chicken Pox
☐ Convulsions
☐ Diabetes
☐ Seizure Disorder/Epilepsy*
☐ Hearing Impairment
☐ Hemophilia*
☐ Hepatitis (A, B or C)*
☐ High Blood Pressure
☐ Hives
☐ Kidney Problems
☐ Liver Problems
☐ Low Blood Pressure
☐ Lupus
☐ Measles
☐ Mitral Valve Prolapse*
☐ Mononucleosis
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sickle Cell Anemia*
☐ Skin Rash
☐ Tonsillitis
☐ Tuberculosis*
☐ Excessive Gagging
☐ Fainting or Dizziness
☐ Prosthetic Joints*
☐ Sickle Cell Trait

*** Indicates we will need medical clearance from doctor's office or pre-medication is required before appointment.**

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information that has not been covered above:
____
____

Dental History

What is the primary reason for today's visit? ____
Is the child currently in pain: __Y __N Has the child ever had any pain/tenderness in his/her jaw joint? __Y __N
Has the child ever had any injuries to his/her teeth, mouth, head or jaw? __Y __N If yes, describe: ____________________
Has the child ever experienced problems with previous dental work? _Y _N If yes, explain: ____________________
Is the child's water fluoridated? __Y __N
Brush his/her teeth daily? __Y __N
Floss his/her teeth daily? __Y __N
Is the child taking fluoridated supplements? __Y __N
Does an adult assist with brushing? __Y __N
Does an adult assist with flossing? __Y __N

Does/did the child have any of the following habits?

Y N Lips sucking/biting
Y N Nail biting
Y N Mouth Breather
Y N Clenching/grinding teeth
Y N Used pacifier until age ___
Y N Nursing bottle habits until age ___
Y N Thumb/finger sucking until age ___
Y N Tongue/cheek biting
Y N Tongue thrust

*I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform necessary dental services my child may need.

Signature ________________________________ Date ______________________

Welcome to Kids First Dental

Children's Names____

Parent #1 Information

__Mother __Father __Stepmother __Stepfather __Grandmother __Grandfather __Guardian

Name:_________________________________ Date of Birth:_____________________

Home Address:______________________ City:___________ State:_____ Zip________

Home Phone:________________ Cell Phone:_________________ Work:______________

May We Contact You At Work? __Y __N Occupation:________________ SSN:_________________

Employer's Name____

E-Mail Address:____

Emergency Contact Name:___________________ Relationship to Patient:____________ Phone Number:______

Parent #2 Information

__Mother __Father __Stepmother __Stepfather __Grandmother __Grandfather __Guardian

Name:_________________________________ Date of Birth:_____________________

Home Address:______________________ City:___________ State:_____ Zip________

Home Phone:________________ Cell Phone:_________________ Work:______________

May We Contact You At Work? __Y __N Occupation:________________

E-Mail Address:____

Employer's Name____

Emergency Contact Name:___________________ Relationship to Patient:____________ Phone Number:______

Responsible Party

The responsible party on your child's account is the parent who most commonly brings your child(ren) for their regular dental visits. This person will receive most of the information from our office regarding preventative care, diagnosis proposed treatment and will thus make decisions which best suits your family's dental needs. This person is also the contact for your child(ren). Please list the name of the responsible party for your family.

Responsible Party Name:____________________________ Relationship to Patient:____________

Date of Birth:___________________ Sex: __M __F Day Time Phone Number:_____________________

Address:_________________________________ City:_____________ State:_______ Zip:_______

How Did You Hear About Us?Friend (Name)_______________ __Sign __Flyer __Internet __Radio (staion)________ __TV Commercial

Kids First Dental

NAME OF PRACTICE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, have received a copy of this office's Notice of Privacy Practices.

Print Patient's Name: ____

Please list any individuals that may bring your child/children to the dentist in the future.

____

____

Signature: _______________________________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining the acknowledgement.
- Other (please specify).

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