Kids Plus Pediatric Dentistry, P.C.

DEMOGRAPHIC INFORMATION

Name of Child_____Date_____
Date of Birth_____Age_____Sex_____
Home Address_____
Street City State Zip code
Home Phone_____
School_____Grade_____
Names and *ages* of other children in family_____
Parent/Guardian_____ Married Single Other_____
How do you wish to be addressed?_____
Cell Phone_____Email_____
Employer_____Work Phone_____
How do you prefer to be contacted? Home Cell Work
Parent/Guardian_____Married Single Other_____
How do you wish to be addressed?_____
Cell Phone_____Email_____
Employer_____Work Phone_____
How do you prefer to be contacted? Home Cell Work
Who has legal custody of patient?_____
Person responsible for account_____SS#_____DOB_____
Dental Insurance Co._____Group #_____
Whom may we thank for referring you to us?_____
What is the reason for your child's dental visit?_____

HEALTH HISTORY

□ YES □ NO Is your child in good health?
Name of Pediatrician_____Clinic/Hospital_____
Pediatrician Phone_____Date of last exam_____
□ YES □ NO Has your child ever had a health problem? _____
□ YES □ NO Has your child ever been hospitalized? Please give reasons and dates_____
□ YES □ NO Is your child allergic to anything? _____
□ YES □ NO Is your child currently taking any medications? Please give medication, dose, and reason_____
□ YES □NO Is your child up to date on the state of Illinois immunization guidelines?
□ YES □NO Is your child up to date on the state of Illinois vaccination guidelines?

Please circle if your child has been treated for any of the following:

Heart disease	Bleeding/transfusions	Asthma/breathing
Liver/GI disease	Anemia	Diabetes
Kidney disease	Rheumatic fever	AIDS/HIV
Speech/hearing	Seizures	Hepatitis
Cerebral palsy	Cleft lip/palate	Blood dyscrasias
Cancer/tumors	Congenital birth defects	Mental delays
Physical delays	Autism	Personality/social
Recurrent headaches	Frequent infections	Adverse drug rxn
Eyesight	Significant injuries	Endocrine/growth

Please elaborate on any items circled:_____
_____

Do you consider your child to be □ advanced in the learning process
□ progressing normally
□ slow in the learning process

Was your child □ breast fed □ bottle fed At what age stopped?_____

DENTAL HISTORY

□ YES □ NO Has your child ever been to the dentist? Name of dentist and date _____

□ YES □ NO Has your child experienced any unfavorable reaction from previous dental care? Explain_____

□ YES □ NO Does your child suck a finger, thumb or pacifier?

□ YES □ NO Does your child have pain with chewing, yawning or wide opening?

□ YES □ NO Does your child's jaw make noise and is pain associated with the sounds?

Please check if your child is having problems with any of the following:

□ Cavities □ Toothache □ Teeth Sensitive
□ Trauma □ Gum Infections □ Color of Teeth
□ Orthodontics □ Jaw Sounds □ Other

Comments:_____
_____
_____
_____

FLUORIDE HISTORY

□ YES □ NO Is your home water supply fluoridated?

□ YES □ NO Does your child use a fluoridated toothpaste?

□ YES □ NO Do you give your child another form of fluoride? What? _____

□ YES □ NO Does your child participate in a school fluoride rinse program?

CONSENT FOR DENTAL TREATMENT

I request and authorize our dental providers to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by our doctors to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Our dental providers will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature_____Date_____

Providers Signature_____Date_____