The Kids' Dentist

**ONLY A PARENT OR LEGAL GUARDIAN CAN FILL OUT THIS FORM –ARE YOU THE LEGAL GUARDIAN OF THE PATIENT LISTED BELOW? YES/NO**

## PLEASE TELL US ABOUT YOUR CHILD-

FIRST NAME_____ LAST NAME_____ NICKNAME_____ MALE/FEMALE

DATE OF BIRTH_____ AGE_____ SCHOOL/PRESCHOOL_____ GRADE_____

WITH WHOM DOES CHILD LIVE?_____ CHILD'S CELLPHONE _____

NAME/AGE SIBLINGS_____ INTERESTS/HOBBIES_____

**DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS? (PLEASE CIRCLE ALL THAT APPLY)**

LIP SUCKING/BITING NAIL BITING
PEN/PENCIL CHEWING
CLENCHING/GRINDING
TOBACCO PRODUCTS
THUMB SUCKING (WHEN_____)
FINGER SUCKING (WHEN_____)
ICE CRUNCHING
PACIFIER (WHEN_____)
TONGUE/CHEEK BITING
GOING TO BED WITH BOTTLE
GOING TO BED WITH SIPPER
TONGUE THRUSTING

## PLEASE TELL US ABOUT YOU-PLEASE FILL OUT BOTH SECTIONS.

**___MOTHER ___STEPMOTHER ___GRANDMOTHER ___GUARDIAN/OTHER**

NAME_____ DATE OF BIRTH_____ SS#_____

HOME PHONE #_____ CELL PHONE #_____ WORK PHONE #_____

HOME ADDRESS_____ EMPLOYER_____

E-MAIL ADDRESS_____

**___FATHER ___STEPFATHER ___GRANDFATHER ___GUARDIAN/OTHER**

NAME_____ DATE OF BIRTH_____ SS#_____

HOME PHONE #_____ CELL PHONE #_____ WORK PHONE #_____

HOME ADDRESS_____ EMPLOYER_____

E-MAIL ADDRESS_____

**NAME AND NUMBER OF CLOSEST RELATIVE (IN CASE OF EMERGENCY)_____**

## PLEASE TELL US ABOUT YOUR DENTAL INSURANCE-

___NO DENTAL INSURANCE

___INDIANA MEDICAID #_____

NAME OF PRIMARY DENTAL INSURANCE COMPANY_____ GROUP #_____

INSURED'S NAME_____ EMPLOYER_____

NAME OF SECONDARY DENTAL INSURANCE COMPANY_____ GROUP #_____

INSURED'S NAME_____ EMPLOYER_____

CHILD'S PHYSICIAN/PEDIATRICIAN_____ CITY/STATE_____

PHONE NUMBER _____

**HOW DID YOU HEAR ABOUT US? (CIRCLE ANY THAT APPLY)** WORD OF MOUTH WEBSITE FACEBOOK

INSTAGRAM TWITTER YELLOW PAGES BILLBOARD SCHOOL VISITS INTERNET SEARCH

REFERRING DENTIST (NAME) _____ (LOCATION) _____

*ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? YES/NO (CIRCLE ONE)

## PLEASE TELL US ABOUT YOUR CHILD'S MEDICAL HISTORY

**HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING?**

**YES/NO** HEART MURMUR / CONGENITAL HEART DISEASE
**YES/NO** LIVER/STOMACH PROBLEMS
**YES/NO** HEMOPHILIA/BLEEDING DISORDERS
**YES/NO** KIDNEY PROBLEMS
**YES/NO** ADENOIDECTOMY/ TONSILLECTOMY
**YES/NO** AUTISM SPECTRUM DISORDER
**YES/NO** FREQUENT EAR INFECTIONS
**YES/NO** PREMATURE BIRTH
**YES/NO** ASTHMA (DATE OF LAST ATTACK) _____
**YES/NO** HEARING PROBLEMS
**YES/NO** MAJOR INJURY
**YES/NO** BREATHING/LUNG PROBLEMS/RSV/CF
**YES/NO** SPEECH DELAY
**YES/NO** SLEEP APNEA/SNORING
**YES/NO** HYPERACTIVITY/ATTENTION DEFICIT DISORDER
**YES/NO** VISION PROBLEMS

**YES/NO** FREQUENT HEADACHE
**YES/NO** HIV/AIDS
**YES/NO** FREQUENT HOSPITALIZATIONS
**YES/NO** CEREBRAL PALSY/NEUROLOGICAL DISEASE
**YES/NO** DIABETES/THYROID/ENDOCRINE PROBLEMS
**YES/NO** CONGENITAL BIRTH DEFECT
**YES/NO** SICKLE CELL DISEASE OR TRAIT
**YES/NO** CANCER/TUMORS/BLOOD DISEASE
**YES/NO** MENTAL DELAY
**YES/NO** SEIZURE DISORDER (DATE LAST SEIZURE)_____
**YES/NO** RHEUMATIC FEVER
**YES/NO** PHYSICAL DELAY
**YES/NO** GERD/ACID REFLUX
**YES/NO** IS THERE A CHANCE YOUR DAUGHTER IS PREGNANT?

**ALLERGIES**

**YES/NO** MEDICINE ALLERGIES-LIST _____
**YES/NO** LATEX ALLERGY
**YES/NO** SEASONAL/ENVIRONMENTAL ALLERGIES-LIST _____
**YES/NO** FOOD ALLERGIES-LIST _____
**YES/NO** DYE ALLERGIES-LIST COLORS _____
**YES/NO** IS YOUR CHILD CURRENTLY TAKING MEDICATION? LIST NAME AND DOSAGE _____

**PLEASE TELL US ABOUT YOUR CHILD'S DENTAL HISTORY-**

**YES/NO** IS YOUR CHILD HAVING ANY DENTAL PAIN?
**YES/NO** IS THIS YOUR CHILD'S FIRST DENTAL VISIT? IF NOT, PREVIOUS DENTIST AND DATE_____
**YES/NO** HAS YOUR CHILD EVER INJURED HIS/HER MOUTH OR TEETH, EVEN AS AN INFANT? IF YES, PLEASE EXPLAIN CIRCUMSTANCES AND AGE OF OCCURANCE_____
**AT WHAT AGE DID YOUR CHILD STOP-**
NURSING/BOTTLE FEEDING? _____ SIPPER CUP? _____
**YES/NO** DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF MISSING OR EXTRA TEETH?
**YES/NO** DO YOU HELP YOUR CHILD BRUSH AND FLOSS DAILY?

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE PRECEDING QUESTIONS AND CERTIFY TO THE TRUTH OF ALL INFORMATION GIVEN. I WILL NOT HOLD DR. WINN OR ANY MEMBER OF HER TEAM RESPONSIBLE FOR ERRORS OR OMISSIONS I HAVE MADE IN THE COMPLETION OF THIS FORM. I UNDERSTAND THAT THE INFORMATION WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES. I GIVE DR. WINN PERMISSION TO USE SUCH MEASURES AS DEEMED NECESSARY IN HER PROFESSIONAL JUDGEMENT TO RENDER A DIAGNOSIS FOR MY CHILD. ALL DIAGNOSTIC AIDS, SUCH AS X-RAYS AND MODELS, ARE THE PROPERTY OF THIS OFFICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED BY MY FAMILY, REGARDLESS OF INSURANCE COVERAGE AND THAT **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED**. IF MY ACCOUNT REQUIRES SERVICING BY A COLLECTION AGENCY, I UNDERSTAND THAT I WILL BE LIABLE FOR THE COLLECTION FEES AND ANY APPLICABLE COURT COSTS, IN ADDITION TO MY OUTSTANDING BALANCE. I ALSO REQUEST THAT PAYMENT UNDER MY DENTAL INSURANCE BE MADE PAYABLE TO DR. TERRI WINN ON ANY SERVICES PROVIDED FOR MY FAMILY. I AUTHORIZE THE RELEASE OF ANY DENTAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ANY FUTURE CLAIMS. THIS AUTHORIZATION SHALL CONTINUE INDEFINITELY UNLESS REVOKED BY ME IN WRITING. THE KIDS' DENTIST DOES NOT ASSUME ANY LIABILITY FOR CHILDREN WHILE THEY ARE PLAYING ANYWHERE ON THE KIDS' DENTIST PREMISES. PARENTS/ACCOMPANYING ADULTS ARE EXPECTED TO SUPERVISE THEIR CHILDREN WHILE PLAYING. BY SIGNING BELOW, PARENT/GUARDIAN RELEASES THE KIDS' DENTIST FROM ALL LIABILITY FOR ANY INJURIES THEIR CHILD MAY RECEIVE WHILE ON THE KIDS' DENTIST PREMISES.

SIGNED_____ DATE_____ WITNESS_____

## ADDITIONAL AUTHORIZATIONS

I give permission for _____ (Name), _____ (Relationship) to authorize treatment for my child in the event that I am unavailable.

_____ (Parent) _____ (Date)

Dr. Signature _____