Welcome!

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Tell Us About Your Child

Today's Date: _____ Child's Home Phone #: _____ Social Security #: _____

Child's Name: _____ (Last / First / MI) Child's Birthdate: _____ Child's Age: _____

Nickname: _____ ❑ Male ❑ Female Is this child adopted? ❑ Yes ❑ No School: _____ Grade: _____

Child's Home Address: _____ (Street / City / State / Zip)

Whom may we thank for referring you? _____

Parent's/Guardian Information

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

❑ **Mother/** ❑ **Father** Birthdate: _____ Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Email Address: _____

Name: _____ Social Security #: _____ Driver's License #: _____

Address: _____ (Street / City / State / Zip)

Employer: _____

❑ **Father/** ❑ **Mother** Birthdate: _____ Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Email Address: _____

Name: _____ Social Security #: _____ Driver's License #: _____

Address: _____ (Street / City / State / Zip)

Employer: _____

Billing Address if different than above: _____ (Street / City / State / Zip)

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____ (PO Box/Street / City / State / Zip)

Insured's Name: _____ Relationship to Patient: _____

Insured's Birthdate: _____ Social Security #: _____ Insured's Employer: _____

Employer's Address: _____ (Street / City / State / Zip)

Secondary Insurance

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____ (PO Box/Street / City / State / Zip)

Insured's Name: _____ Relationship to Patient: _____

Insured's Birthdate: _____ Social Security #: _____ Insured's Employer: _____

Employer's Address: _____ (Street / City / State / Zip)

CONTINUED ON BACK

Dental History

Is the child currently in pain? ❑ **Yes** ❑ **No** **What is the primary reason for today's visit?** _____

Has the child experienced problems with previous dental work? ❑ Yes ❑ No

Does the child brush his / her teeth daily? ❑ Yes ❑ No Floss his / her teeth daily? ❑ Yes ❑ No

Previous Dentist: _____ Date of Last Visit: _____

Why did you leave your child's previous dentist? _____

Is your child taking fluoride? ❑ Yes ❑ No Is your water fluoridated? ❑ Yes ❑ No

Does your child have any special fears or concerns (ie: Afraid of bugs)? _____

Does / did the child have or do any of the following?

❑ Lip Sucking / Biting	❑ Clenching / Grinding Teeth	❑ Tongue / Cheek Biting	❑ Sippy Cup Usage
❑ Nail Biting	❑ Thumb / Finger Sucking	❑ Pacifier Usage	❑ Speech Problems
❑ Chewing on Objects	❑ Nursing Bottle Habits	❑ Tongue Thrust	❑ Breast Fed

Important Medical Information

Child's Physician: _____ Phone #: _____ _____ Date of last visit: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? ❑ Yes ❑ No Please explain: _____

Please describe the child's current physical health: ❑ Good ❑ Fair ❑ Poor **Are Immunizations Current?** ❑ Yes ❑ No

Please list all drugs that the child is currently taking: _____

Please list all drugs/over the counter products and/or things that cause the child allergic reactions:

_____

Anything you would like to discuss with the Doctor in private? ❑ Yes ❑ No

Has the child had/experienced any of the following:

❑ Abnormal/Prolonged Bleeding	❑ Cancer	❑ High Blood Pressure	❑ Recurrent Ear Infections
❑ AIDS / HIV+	❑ Chicken Pox	❑ Hives	❑ Recurrent Tonsillitis
❑ AIDS / HIV+ (exposed but neg)	❑ Congenital Heart Defect or Disease	❑ Kidney Problems	❑ Rheumatic Fever
❑ Allergies	❑ Convulsions / Seizures / Epilepsy	❑ Latex Allergies	❑ Scarlet Fever
❑ Anemia	❑ Diabetes	❑ Liver Problems	❑ Shunts
❑ Anorexia/Eating Disorders	❑ Handicaps / Disabilities	❑ Low Blood Pressure	❑ Sickle Cell Anemia
❑ Any Hospital Stay / Operations	❑ Hearing Impairment	❑ Measles	❑ Skin Rash
❑ Asthma	❑ Heart Murmur	❑ Mononucleosis	❑ Spina Bifida
❑ Autism/Behavior Disorder	❑ Hemophilia	❑ Primary Herpes	❑ Tonsillitis
❑ Blood Transfusion	❑ Hepatitis	❑ Prolonged/Chronic High Fevers	❑ Tuberculosis (TB)

Please discuss any serious medical problems the child experiences/ed:

_____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infections control mandated by OSHA, the CDC and the ADA.

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign the Doctor all insurance benefits. I understand that **I am responsible for payment of services rendered**, any deductible, and co-payment that my insurance does not cover. I authorize that a report of this child can be sent to child's physicians. By signing this I indicate that I have legal authorization to consent to care and treatment by Dr. Kotlow.

_____
Signature Date