



We are delighted to have you as a new patient. May we extend our sincere thanks for the opportunity to meet your child's dental needs. We look forward to a continued relationship with you!

WELCOME TO OUR PRACTICE!

1 Tell Us About Your Child

Child's Name _____

Nickname _____

★ Male ★ Female

Birthdate _____ Age _____

Mobile/Home # _____

SS# _____

Home Address _____

2 Mother's Information

Name _____

★ Mother ★ Stepmother ★ Guardian

Birthdate _____

Employer _____

M# _____ H# _____ Othr# _____

SS# _____

3 Father's Information

Name _____

★ Father ★ Stepfather ★ Guardian

Birthdate _____

Employer _____

M# _____ H# _____ Othr# _____

SS# _____

4 Who is Accompanying the Child

Name _____

Relationship _____

Do you have legal custody of this child?

★ Yes ★ No

5 Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

M# _____ H# _____ Othr# _____

E-mail _____

6 Primary Dental Insurance

Ins. Co. Name _____

Address _____

Ins. Co. Phone# _____

Group # _____

Policy Owner's Name _____

SS# or ID# _____

Policy Owner's Employer _____

7 Secondary Dental Insurance

Ins. Co. Name _____

Address _____

Ins. Co. Phone# _____

Group # _____

Policy Owner's Name _____

SS# or ID# _____

Policy Owner's Employer _____

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



8 Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last dental exam? _____

Were x-rays taken at previous dental visit? _____

Have there been any injuries to the teeth, face or mouth? ★ Yes ★ No

If yes, please explain: _____

Why did you bring your child to the dentist today? _____

Does the child have any of the following habits?

Y N Lip Sucking/Biting Y N Nail Biting
Y N Nursing bottle habits Y N Finger habit

Has the child ever had a serious or difficult problem associated with previous dental work? ★ Yes ★ No

If yes, please explain _____

Is the child's water fluoridated? ★ Yes ★ No

Is the child taking any fluoride supplements? ★ Yes ★ No

Has the child ever had any pain or tenderness in his/her jaw? _____

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

Floss his/her teeth daily? ★ Yes ★ No

Is he/she active in sports? ★ Yes ★ No

9 Health History

Has the child ever had any of the following

Y N	Abnormal Bleeding	Y N	Handicaps/Disabilities
Y N	Allergies to any Drugs	Y N	Hearing Impairment
Y N	Any Hospital Stays	Y N	Heart Murmur
Y N	Any Operations	Y N	Hemophilia
Y N	Asthma	Y N	Hepatitis
Y N	Cancer	Y N	HIV/AIDS
Y N	Congenital Heart Disease	Y N	Kidney/Liver Problems
Y N	Convulsions/Epilepsy	Y N	ADD/ADHD
Y N	Rheumatic/Scarlet Fever	Y N	Allergies to Latex
Y N	Frequent ear infections	Y N	Autism

Please discuss any serious medical problems the child has had _____

Please list all the drugs the child is taking _____

Please list all allergies _____

Is the child currently under the care of a physician? _____

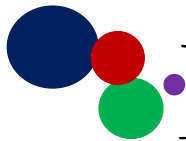
Child's Physician _____

Phone # _____

Please describe the child's current physical health

★ Good ★ Fair ★ Poor

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Tell us how you heard about Just Kidz Dentistry: _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and 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 dental services my child may need.

Printed Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____

Date: _____

Relationship to Patient: _____

Email & Text Appointment Reminders!- We invite you to participate in our online system.

Email: _____ Email Opt OUT Parent/Guardian Initial _____

Mobile: _____ Text Opt OUT Parent/Guardian Initial _____

"We're in this together!"