

Kids First Dentistry LLC.

Pediatric Dentist

The place where Kids come First

Please fill in the personal history on the following pages. This information is an important aid in making a thorough evaluation of your child's dental health. It also allows us to more adequately plan for your child's emotional and dental needs.

THIS MATERIAL IS STRICTLY CONFIDENTIAL

Patient Information

Date _____ Male Female
 Child's Name _____
 Nickname _____
 Age _____ Birthdate _____
 Address _____

 Town _____ Zip Code _____
 Phone _____
 Mother's Name _____ DOB _____
 Social Sec. No. _____
 Mother Employed By _____
 Cell Phone _____
 Father's Name _____ DOB _____
 Social Sec. No. _____
 Father Employed By _____
 Cell Phone _____
 Married Single Divorced Widowed

Whom may we thank for referring you to us?

Dental Insurance

Who is responsible for this account? _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____
 ID # _____
 Is patient covered by additional insurance? Yes No

I, the undersigned certify that I (or my dependant) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____

Date _____

Dental History

Is this the child's first visit to the dentist? Yes No
 Date of the last visit and reason _____
 Name of Dentist _____
 How often does your child brush his/her teeth? _____
 Do you assist? Yes No
 Has your child ever had dental x-rays? Yes No
 Date _____
 Where _____
 Are you seeking complete dental care for your child?
 Explain _____
 Has any member of your family had any unusual dental problems?
 Yes No

Does your child have a history of: (If yes, please check)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Pacifier Use | <input type="checkbox"/> Cheek Biting | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Nail or Object Biting | <input type="checkbox"/> Tongue Thrusting | <input type="checkbox"/> Tooth Grinding | <input type="checkbox"/> Mouth Breathing |

Whom may we thank for referring you to us? _____

Has your child ever injured their head, mouth and/or teeth? Yes No
 Explain _____
 Is your child having dental problems now? Yes No
 Explain _____
 Has your child ever had any unfavorable dental experiences? Yes No
 Explain _____
 Does/did your child take a bottle to bed at night? Yes No
 What was in the bottle? _____
 Age of child when they completely stopped using the bottle _____
 Has your child had any teeth removed? Yes No
 Explain _____
 Does your child take fluoride in any form now? Yes No
 How _____

Medical History

Child's Physician _____

Phone _____

Are all immunizations up to date?

Condition of child's health _____

Date and reason for last examination by physician _____

Was pregnancy and delivery normal?

If no, please explain _____

Has your child ever had a general anesthetic?

If yes, please explain _____

Is your child allergic to any medications?

If yes, list all medications _____

Are there any other allergies?

If yes, please list _____

Is your child taking medications now?

If yes, please list _____

Reasons for medication(s) _____

Medical Conditions

Does your child have/has your child ever had any of the following:

N Y

Cerebral Palsy

Developmentally Delayed

Learning Disability

Psychiatric Care/Emotional Ailments

Hyperactivity/ADHD

Extreme Nervousness or Apprehension

Anemia or Blood Ailments

Excessive Bleeding from Cut or Extraction

Asthma or Other Respiratory Ailments

Liver Ailments, Jaundice or Hepatitis

N Y

Heart Ailments

Rheumatic Fever

Epilepsy or Seizures

Heart Murmur

Sinus Ailments

Tonsillitis

Tuberculosis

Kidney Ailments

Diabetes

Aids/HIV+

N Y

Thyroid Disorders

Ulcer or Colitis

Malignancies or Leukemia

Chicken Pox

Mononucleosis

Hearing Ailments

Eye Disorders

Physical Handicaps

Other _____

Describe any current medical treatment not listed above _____

Social History

Interests _____

Favorite Toys _____

Sports Played _____

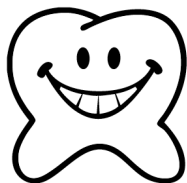
Pets _____

Special Experiences _____

Please list any questions that you would like answered:

Parent/Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____



X-Rays, Cleaning & Coverage Information

Date of last cleaning _____

Place of last cleaning _____

Date of last X-Rays _____

If a cleaning and x-rays were performed within the last six months, most insurance companies will **NOT** cover the fees.

Therefore, if a cleaning/x-ray is necessary and completed in this office within SIX MONTHS of a previous cleaning/set of x-rays, it is responsibility of the parent or guardian to cover the fees your insurance does not cover.

INSURANCE:

Your Insurance MAY NOT COVER the services entirely, or at all. Any ESTIMATE given by this office is considered a guideline until the EOB (Explanation of Benefits) is received by our office and the patient's account is reconciled. This office makes **NO GUARANTEES** of the actual payment by your insurance company.

PAYMENT:

Payments, co-payments and deductibles are to be made in full before treatment has begun. If for any reason you feel you will be unable to render payment in full, please notify us at the beginning of your visit.

We accept cash, personal checks, Discover, Master Card, Visa, AMEX.

In the event that x-rays, cleanings or fluoride done within six months of today's date are not covered by the patients insurance; and in the event that any procedures done at Kids First Dentistry LLC are not covered by the insurance company (i.e. NO2 Sedation, Sealants and replacement of space maintainers),

I _____, will take full financial responsibility.

Signature: _____

Date: _____