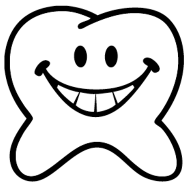


Kids First Dentistry LLC.
Pediatric Dentist
The place where Kids come First

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 herby 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 you 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

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 ________________________________

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

❑ Thumb sucking ❑ Pacifier Use ❑ Cheek Biting ❑ Speech Problems

❑ Nail or Object Biting ❑ Tongue Thrusting ❑ Tooth Grinding ❑ Mouth Breathing

Whom may we thank for referring you to us? ________________________________

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		N	Y		N	Y	
❑	❑	Cerebral Palsy	❑	❑	Heart Ailments	❑	❑	Thyroid Disorders
❑	❑	Developmentally Delayed	❑	❑	Rheumatic Fever	❑	❑	Ulcer or Colitis
❑	❑	Learning Disability	❑	❑	Epilepsy or Seizures	❑	❑	Malignancies or Leukemia
❑	❑	Psychiatric Care/Emotional Ailments	❑	❑	Heart Murmur	❑	❑	Chicken Pox
❑	❑	Hyperactivity/ADHD	❑	❑	Sinus Ailments	❑	❑	Mononucleosis
❑	❑	Extreme Nervousness or Apprehension	❑	❑	Tonsillitis	❑	❑	Hearing Ailments
❑	❑	Anemia or Blood Ailments	❑	❑	Tuberculosis	❑	❑	Eye Disorders
❑	❑	Excessive Bleeding from Cut or Extraction	❑	❑	Kidney Ailments	❑	❑	Physical Handicaps
❑	❑	Asthma or Other Respiratory Ailments	❑	❑	Diabetes			Other ______________
❑	❑	Liver Ailments, Jaundice or Hepatitis	❑	❑	Aids/HIV+			______________

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:

____

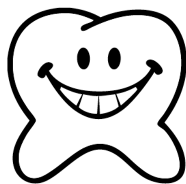
____

____

Parent/Guardian's Signature ______________________ Date ____________

Doctor's Signature ______________________ Date ____________

David J. Song, DMD
Pediatric Specialty Permit 5541



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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: ____

Main Street Village Executive Center
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