Just Kids
PEDIATRIC DENTISTRY

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Welcome

Board Certified - American Academy of Pediatric Dentistry

Please tell us about your child

PLEASE PRINT

Today's Date__/__/__ Child's Home Phone # ( )____-_____ Social Security #_ ___-___-_____
Child's Name: _____Nickname:_____Birth date_____
Child's Home Address:_____City/State_____Zip_____
Male __Female__School_____Grade_____
Do Mother, Father and Child live together? Yes __No__ If no, please explain:_____
Do you consider your child to be hyperactive or generally nervous? Yes __ No__
Do you expect your child to be cooperative in the office? Yes __ No__
What is your child's special hobby, interests or likes_____
Are other family members patients: Yes__No__ If yes, please give patients name:_____
Referred by:_____Person to contact in case of emergency_____Phone___-_____

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Who is Accompanying The Child Today?

Name:_____Relation:_____Do you have legal custody of this child? Yes___ No_____
Is the child adopted? Yes__ No__ Is the child in a foster home? Yes__ No__ Other_____

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Parent Information

Mother's Name:_____**Social Security#**___-___-_____**Birthdate**__/___/___
Cell Ph _____-_____ **e-mail address**_____
Home Address:_____**City/State**_____**ZIP**_____ **Home Ph**_____-_____
Employer:_____**Occupation**_____**Address**_____**Ph**_____-_____
Father's Name:_____**Social Security #**___-___-_____**Birthdate**___/___/_____
Home Address:_____**City/State**_____**ZIP:**_____**Home Ph**_____-_____
Employer:_____**Occupation**_____**Address**_____**Ph**_____-_____

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Medical History

Child's Physician or Pediatrician_____ Is child seen regularly: Yes__ No__ Date Last Seen__/__/___
Is your child in good health? Yes__ No__ Is your child taking any medications now? Yes__ No__
What_____
Has your child had any unfavorable or allergic reaction to foods, latex, local anesthetics, or medications, including penicillin or aspirin? Yes__ No__

HAS YOUR CHILD HAD/EXPERIENCED ANY OF THE FOLLOWING (Please check those that apply):

___Abnormal Bleeding
___Aids
___Allergies
___Asthma
___Blood Disorder
___Brain Injury
___Cancer
___Cerebral Palsy
___Chicken Pox
___Congenital Heart Defect
___Convulsions
___Diabetes
___Epilepsy
___Emotional Problems
___Eye Problem
___Glandular Problem
___Handicaps/Disabilities
___Hearing Impairment
___Heart Murmur
___Hemophilia
___Hepatitis
___High Blood Pressure
___Hives
___Kidney Problems
___Liver Problems
___Low Blood Pressure
___Lung Disease
___Measles
___Mental Disturbances
___Mumps
___Pneumonia
___Rheumatic Fever
___Rubella
___Serious Illness
___Sickle Cell Anemia
___Speech Impediment
___Stomach Problem
___Throat Problem
___Tuberculosis (TB)

Has your child been hospitalized or treated in the Emergency Room? Yes__ No__
Has your pediatrician ordered any particular diet for your child? Yes No___
Does your child dislike or refuse any foods? Yes ___ No___ If yes what _____
Child's favorite snack_____When_____Child's favorite drink_____

Dental History

Is this your child's first visit to the dentist? Yes__ No__ Is the child currently in pain? Yes __ No __
Is there anything in your child's mouth that concerns you? Yes __ No __ Describe:_____
Has your child experienced any unfavorable reactions from any previous dental or medical care? Yes__ No__
If yes, please describe:_____
Have x-rays been made of your child's teeth within the last six months? Yes __ No __
Who brushes your child's teeth _____How often?_____Is floss used Yes__No__
Does your child use fluoride toothpaste? Yes__ No__ Water Supply: City___ Well___
DOES/DID YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS (Please check those that apply):

___Lip sucking/biting	___Clenching/grinding teeth	___Tongue/cheek biting
___Nail biting	___Use/used pacifier	___Speech problems
___Chewing on objects	___Nursing bottle habits	___Tongue thrust
___Mouth breather	___Thumb/finger sucking	___Breast fed

Insurance Information

PRIMARY COVERAGE:
Medical Coverage? Yes__ No__ Dental Coverage? Yes __ No __ Orthodontic Coverage Yes __ No__
Insurance Co. Name: _____ Phone #: (____)_____-_____ Group#:_____
Insurance Co. Address _____City/State_____ZIP_____
Policy Owner's Name _____Relationship to Patient:_____
Policy Owner's Birthdate:__/__/__ Social Security #____-___-_____ Employer: _____
Employer's Address _____Employer Phone #: (___) ____-_____
Secondary Coverage:
Medical Coverage? Yes__ No__ Dental Coverage? Yes __ No__ Orthodontic Coverage Yes__ No___
Insurance Co. Name:_____Phone #: (____) ____-_____Group#:_____
Insurance Co. Address _____City/State_____ZIP_____
Policy Owner's Name_____Relationship to Patient:_____
Policy's Owner's Birthdate__/__/__ Social Security # _____-___-_____ Employer_____
Employer's Address: _____Employer Phone # (_____)_ ___-_____
INSURANCE AUTHORIZATION:
I authorize use of this form on all my insurance submissions.....Yes__No__
I authorize release of information to all my insurance carriers.....Yes__No__
I understand that I am responsible for my bill.....Yes__No__
I authorize my dentist to act as my agent in helping me obtain payment form my insurance carriers .....Yes__No__
I authorize payment directly to my dentist.....Yes__No__
I understand that even though I have insurance coverage, I am responsible for payment of services if payment is not made by my insurance carrier within thirty (30) days.

SIGNATURE_____**Date**__/__/__

Medicaid Patients Only

Social Worker's Name _____Phone # (____)_ ___-_____

Authorizations

I AFFIRM THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. 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.

AUTHORIZATION IS HEREBY GRANTED TO PERFORM THE NECESSARY PROCEDURES FOR DIAGNOSIS AND TREATMENT TO INCLUDE ADMINISTRATION OF THE NECESSARY MEDICATION AS PREVIOUSLY TREATMENT PLANNED.

THE POLICY IN OUR OFFICE IS THAT THE PARENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COST OF DENTAL TREATMENT AS PREVIOUSLY TREATMENT PLANNED TO ME.

MY METHOD OF PAYMENT WILL BE: CASH____ VISA ____ MASTERCARD____DISCOVER____ OTHER_____

SIGNATURE_____**Date** __/__/__

Notes