Kids@Heart
PEDIATRIC DENTISTRY

NEW PATIENT INFORMATION AND HEALTH HISTORY

PATIENT INFORMATION

Name _____DOB_____Age_____

Address _____

City _____State _____ Zip Code _____

If patient is a student, name of school _____

City _____State _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Name _____DOB _____

Address _____

_

City _____ State _____ Zip Code _____

Home Phone # _____Cell Phone # _____Work Phone # _____

_

Relationship to Patient_____

Responsible Party E-mail _____

Social Security Number _____

INSURANCE INFORMATION

Name of Policy Holder _____ DOB _____

Insurance Company _____

Insurance Address _____

City _____ State _____ Zip Code _____

Insurance Phone # _____Group Number _____

Social Security Number _____ Subscriber ID _____

Relationship to Patient _____

ADDITIONAL INSURANCE INFORMATION

Name of Policy Holder _____ DOB _____

Insurance Company _____

Insurance Address _____

City _____ State _____ Zip Code _____

Insurance Phone # _____Group Number _____

Social Security Number _____ Subscriber ID _____

Relationship to Patient _____

PATIENT MEDICAL HISTORY

Please Circle YES or NO

- Is your child under the care of a physician? YES NO

Physician's Office Name _____Physician's Name_____
Physician's Office Number _____Date of last exam _____

- Has your child been hospitalized in the last five years ? Please explain below YES NO

_____

_____

- Is your child taking medications? Including over the counter and prescriptions YES NO
- Does your child have any allergies? Please list below YES NO

_____

_____

For Female Patients:

Is the patient pregnant? YES NO
Is the patient nursing an infant? YES NO
Is the patient on birth control? YES NO

- Has your child ever had a reaction to anesthetic? Please explain below YES NO

_____

_____

_____

PLEASE CHECK ALL THAT APPLY

__ADD/ADHD
__Anemia
__Asthma
__Autism
__Bleeds/Bruises Easily
__Bone/Joint Problem
__Cancer
__Cleft Lip/Palate
__Congenital Birth Defect
__Development Delay
__Diabetes
__Ear Infections/Recurrent
__ Hearing/Visual Problem
__ Hearth Anomaly
__ Hypo/Hyperthyroid
__ Immunocompromised
__ Infectious Disease
__ Kidney Problem
__ Liver Disease
__ Neurological Disorder
__ Respiratory Problem
__ Seizures
__ Sickle Cell Anemia
__ Syndrome (i.e. Down)

DENTAL HISTORY

Please Circle YES or NO

- Does your child's gums bleed while brushing or flossing? YES NO
- Are your child's teeth sensitive to hot or cold liquids/foods? YES NO
- Does your child feel pain in any of his/her teeth? YES NO
- Does your child have any sores or lumps in his/her mouth? YES NO
- Has your child ever suffered trauma to his/her face/mouth or jaw? YES NO
- Does your child have any pain in his/her jaw joint, ear, or side of the face? YES NO
- Does your child have difficulty opening or closing his/her mouth? YES NO
- Does your child clench or grind their teeth? YES NO
- How many times a day does your child brush his/her teeth _____
- Does your child use mouth rinse? YES NO
- Has your child had any traumatic dental experiences in the past? YES NO

Goals for your child's mouth, teeth and smile:

_____

_____

_____

What would you or your child like changed about his/her smile?

_____

_____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my child's health.

Parent Signature _____Date_____

Print name _____

Dentist Signature _____Date_____

Witness Signature _____Date_____