Welcome

Tell Us About Your Child:

Patient's Name:
____

Date of Birth: Age:
____

Social Security #:
____

Nickname: □ Male □ Female
____

Hobbies: School:
____

Physical Address:
____

Mailing Address:
____

City, State, Zip:
____

Home Phone:
____

Father's Information:

□ Married □ Single
□ Guardian □ Step-Father
□ Foster Parent

Name:
____

Social Security #:
____

Date of Birth:
____

Employer: Work Phone:
____

Home Phone: Alt. Phone:
____

Driver's License: Exp:
____

Mother's Information:

□ Married □ Single
□ Guardian □ Step-Mother
□ Foster Parent

Name:
____

Social Security #:
____

Date of Birth:
____

Employer: Work Phone:
____

Home Phone: Alt. Phone:
____

Driver's License: Exp:
____

Who is accompanying the child today?

Name: ____
Relation: ______________________________________

Contact E-mail: ___________________________

Do you have legal custody of this child?

□ Yes □ No

In case of an emergency, please call:

Name: ____
Phone: ____
Other family member seen by us:
____
Name and phone # of nearest relative not living with you:
____
____

Person responsible for account:

Name:
____

Relation:
____

Home Phone: Work #:
____

Alt. Phone #:
____

Who may we thank for referring you?

□ Patient □ Doctor □ Other
Name:
____

Address:
____

Phone#:
____

Insurance Information:

ASK US IF WE ARE IN NETWORK

Insured's Name:_________________________________
Insured's Date of Birth: __________________________
Insured's Social Security #: _______________________
Relationship to Patient: __________________________
Employer: _____________________________________
Employer's Address:______________________________
Employ's Phone: ________________________________
Insurance Co. Name: _____________________________
Insurance Co. Address: ___________________________
Insurance Co. Phone: _____________________________
Group: (Plan, Local, or Policy) ____________________

For our patients with dental insurance, we will be happy to file insurance claims for you as long as your insurance can be verified. We ask you to pay all non-covered fees as treatment progresses. If we do not receive payment within five (5) weeks after treatment, you will be expected to pay for all dental services. In the event of a duplicate payment, you will be reimbursed.

____
Signature of Parent/ Guardian

____
Date

Previous/ Present Dentist:

____

Child's Pediatrician:

____

Phone #: Date of last visit:

____

Is your child currently under the care of a physician?
□ Yes □ No

Please describe your child's current physical health:
□ Good □ Fair □ Poor

Please list all drugs that the child is allergic to:

____
____
____

Please list all drugs that the child is currently taking:

____
____
____
____

Does your child have any of the following habits?

Yes	No	
□	□	Thumb/ Finger Sucking
□	□	Lip Sucking/ Biting
□	□	Nail Biting
□	□	Nursing/ Bottle Habits
□	□	Mouth Breathing
□	□	Nighttime Grinding of Teeth

Does your child have a **Heart Condition**?
(Such as a heart murmur)
□ Yes □ No

Explain if yes:

____
____
____

If yes, child's cardiologist's Name and Phone number:

____
____
____

Does the child have/ or ever had any of the following medical problems?

Yes	No	
□	□	Cancer
□	□	Diabetes
□	□	Rheumatic Fever
□	□	HIV +/ AIDS
□	□	Hemophilia
□	□	Asthma
□	□	Hepatitis
□	□	Tuberculosis (TB)
□	□	Chronic upper Respiratory problems
□	□	Convulsions/ Epilepsy
□	□	Abnormal Bleeding
□	□	Hearing Impairment
□	□	Any Operations
□	□	Any Hospital Stays
□	□	Kidney/ Liver problems
□	□	Handicaps/ Disabilities
□	□	Allergies
□	□	Pregnant
□	□	Smoker
□	□	ADD & ADHD
□	□	Developmentally Delayed
□	□	Autism/PDD-NOS

Please discuss any serious medical problems that your child has/had:

____
____
____
____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the doctors and the dental staff to perform any necessary dental services my child may need. The responsible party is the parent who brings the child to the dental office, independent of what a divorce decree may state. Reimbursement must be made between the divorced parties. We will not intervene.

****Only 1 custodial parent/caregiver will be allowed in the treatment room with the patient during treatment. Switching between custodial parents/caregivers will NOT be allowed because of distraction to the patient caused during transitions.****

******<u>VIDEO TAPING</u>** in the office is **<u>forbidden</u>** unless formal consent from Kennedy Dental Care has been obtained prior to treatment. CELLPHONES should be turned off or silent during any preventative or restorative treatment.*****

____
Signature of Parent/Guardian Date

____
Signature of Person Accompanying Child Date