Dublin Kids Dental

1. TELL US ABOUT YOUR CHILDREN

Child's Name: _____
DOB: _____
Child's Name: _____
DOB: _____
Child's Name:_____
DOB: _____
Home #: _____
Home Address: _____
_____
City State Zip

2. PARENT INFORMATION

Mother's Name: _____
Father's Name: _____
Address: _____
_____
City State Zip

Employer: _____
Mom's Cell #: _____
Dad's Cell #: _____
Mom's email: _____ DOB: _____
Dad's email: _____ DOB: _____

3. PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

4. REFERRAL

Who May We thank for Referring You? _____
_____

5. DENTAL HISTORY

I. Last Dental Apt: _____
II.B. Previous Dentist: _____
III. Were X-rays taken? YES NO
IV. Has your child ever had a serious problem associated with dental work? If yes, please explain: _____
_____
V. Any injuries to the face, teeth, or mouth? If yes, please explain
_____
VI. Does your child have any of the following habits?

Y N Lip Sucking/Biting Y N Nail Biting
Y N Nursing Y N Thumb/Finger Sucking

VII. Does your child have pain/tenderness in the jaw/joint? (TMJ/TMD)? YES NO
VII. Does your child brush daily? Y N Floss? Y N
VIII. Child's Physician: _____

6. HEALTH HISTORY

Has your child experienced any of the following:

Y N Abnormal Bleeding	Y N Disabilities
Y N Refulx/GI Issues	Y N ADD/ADHD
Y N Hospital Stays	Y N Hearing Issues
Y N Blood Disorders	Y N Hepatitis
Y N Kidney Problems	Y N Tuberculosis
Y N Heart Disease	Y N Asthma
Y N Birth Defects	Y N Cancer
Y N HIV/ AIDS	Y N Diabetes
Y N Epilepsy	Y N Scarlet Fever

Please discuss any serious medical conditions:
_____
_____
Please list any medication child is currently taking:
_____
Please list any/ all allergies:
_____

I understand that the information 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 authorize dental staff to perform the necessary dental services my child may need.

_____ _____
Signature of Parent/Guardian Date