Kaufman
FAMILY
DENTISTRY

Patient Information

Patient's Name: ______________________________ Nickname: ________________________

Date of Birth: ______________________ Age: ______ Sex: __ M __ F Weight: __________

Interests and Hobbies: ____

School: ___________________________________ Grade: ___________________________

Names and ages of other children in the family: ______________________________________

Parent Information

Name of Parent(s): ____

Home Street Address: ____

City, State, Zip: ____

Home Phone #: _____________ Work Phone # ____________ Cell Phone #: ______________

Is it OK to text you appointment reminders ? Yes No

E-mail Address: ____

Do you have dental insurance? Yes No

Policy Holder's Name: ____

Social Security #: ___________________________ Date of Birth: _______________________

Insurance Name: ________________________________ Member ID #: ________________

Claims Address: ____

Plan Phone #: __________________________________ Group #: ____________________

Emergency Contact

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____________________________ Relation: ____________ Phone #: _____________

Authorization for Treatment of a Minor

Are you the child's legal guardian? Yes No

Will you be bringing the child to appointments? Yes No

If no, only persons listed below are authorized to bring your child to their dental appointment and receive personal medical and dental information. However, only the legal guardian can provide consent for invasive dental treatment. Regardless of who brings the child, you are still responsible for the financial payments on this account. The legal guardian is responsible for making changes regarding the persons authorized on this form.

Authorized Name: ____________________________________ Relation: _________________

Child lives with: Mother Father Both Parents Other ___________________

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment or deductibles that my insurance does not cover. Our office accepts cash, check, all major credit cards, and Care Credit as forms of payment.

Parent Signature: ____ Date: __________________

Medical and Dental History

Has your child ever had any of the following medical problems? If yes, circle and please explain.

ADD/ADHD	Cleft Lip/Palate	Lung Disorder
Allergies to Drugs/Latex	Congenital Heart Defect	Kidney/Liver Problems
Allergies to Foods	Convulsions/Epilepsy	Operations/Hospitalizations
Apraxia	Developmental Delay	Orthopedic Problems
Anemia	Diabetes	Respiratory Disease
Artificial Valves	Digestive Problems	Rheumatic Fever/Heart Disease
Asthma	Disabilities/Handicap	Scarlet Fever
Aspergers	Hearing Impairment	Seizures
Autism	Heart Condition	Sickle Cell Disease/Trait
Behavior Disorder	Heart Murmur	Skin Disorder
Abnormal Bleeding	Hemophilia	Speech Problems
Blood Disease	Hepatitis	Syndromes
Brain Surgery/Disorder	HIV/AIDS	Tuberculosis
Cancer/Tumors	Latex Allergy	Visual Impairment
Cerebral Palsy	Leukemia	OTHER

Please explain any medical problems that your child has that is/is not listed above:

____

____

Who is your child's pediatrician/physician | phone number? ____________________ | ____________________

Yes No Are your child's immunizations up to date?

Yes No Is your child in good health?

Yes No Have you ever been told your child needs antibiotics before dental treatment?

Yes No Is your child under the care of a physician for anything other than routine care? Please explain.

____

Yes No Does your child have any drug allergies or adverse reactions to any medication? Please list.

____

Yes No Is your child taking any medications at this time, including over the counter? Please list.

____

Yes No Has your child ever been hospitalized or treated in the emergency room? When and for what reasons:

____

Yes No Does your child have any social, physical, growth, mental or emotional disorders? Please explain.

____

Dental History

What is the reason for today's visit? ____

Yes No Has your child ever been seen by a dentist before? If yes, name and date: ______________________

Yes No Has your child ever had an unfavorable dental experience?

Yes No Have there been any injuries to your child's face, mouth, or teeth? ______________________

Yes No Does your child suck his/her thumb?

Yes No Have your child's tonsils/adenoids been removed?

Yes No Does your child brush with fluoridated toothpaste?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Parent/Guardian Signature: ______________________________ Today's date: ______________

PATIENT Name: ______________________________ Today's date: ______________