Kim Brown, D.M.D.

Patient Information

Patient Name: _____ Date of Birth: ____/____/____
First Middle Last

Nickname: _____ ☐ Male ☐Female

Patient lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Child's Home Phone #: (_____) _____

SS#: _____

Child's Home Address: _____
Street

_____
City State Zip

Mother's Information

Name: _____ Date of Birth: ____/____/____

☐ Mother ☐ Stepmother ☐ Foster ☐ Guardian

Employer: _____ Work # (_____) _____

Home # (_____) _____ Cellular Phone # (_____) _____

SS # _____ Driver's License # _____

Father's Information

Name: _____ Date of Birth: ____/____/____

☐ Father ☐ Stepfather ☐ Foster ☐ Guardian

Employer: _____ Work # (_____) _____

Home # (_____) _____ Cellular Phone # (_____) _____

SS # _____ Driver's License # _____

Who is Accompanying the Child Today?

Name: _____

Relationship: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Person Responsible for Account

Name: _____

Relationship: _____

Billing Address: _____
Street

_____
City State Zip

Home # (_____) _____ Cellular Phone # (_____) _____

E-mail address: _____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Phone: (_____)_____

Group # _____

Policy Owner's Name: _____

Social Security # _____

Policy Owner's Employer_____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Phone: (_____)_____

Group # _____

Policy Owner's Name: _____

Social Security # _____

Policy Owner's Employer_____

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Child's Name: _____ Birth Date: ____/____/____
First Middle Last

Gender: ☐ Male ☐ Female Nickname: _____

- Present dental problem (if any) as you see it: _____
- Is this your child's first visit to the dentist? ☐ Yes ☐ No
  Name of prior dentist: _____ Date of visit: ____/____/____
  Has your child ever had dental x-rays? ☐ Yes ☐ No If yes, Date: ____/____/____
- Has your child had unpleasant dental experiences? ☐ Yes ☐ No Explain: _____
- Have any other children in your family been to our office: ☐ Yes ☐ No
  Names and ages of other children: _____
- Whom may we thank for referring you to our office? _____

MEDICAL HISTORY

Pediatrician: _____ Date of last physical: ____/____/____
Phone: (____)_____-_____ Address: _____

- Is your child in good health? ☐ Yes ☐ No • Are your child's immunizations current? ☐ Yes ☐ No
- Is your child taking any medications? ☐ Yes ☐ No
  List medications: _____
- Has your child been hospitalized or had surgery? ☐ Yes ☐ No
  If yes, explain: _____
- Is your child allergic to the following? ☐ Latex ☐ Food/ Dyes ☐ Pollen/Dust ☐Other _____
- Does your child have reactions or allergies to any medications? ☐ Yes ☐ No
  List medications and reactions: _____

PLEASE CHECK ***YES OR NO*** REGARDING YOUR CHILD'S HISTORY OF ANY OF THE FOLLOWING

YES	NO		YES	NO		YES	NO	
☐	☐	Allergies to Medications	☐	☐	Chronic Ear Infections	☐	☐	HIV infection
☐	☐	Anemia	☐	☐	Cleft Lip / Palate	☐	☐	Hyperactivity (ADD or ADHD)
☐	☐	Asthma	☐	☐	Convulsions / Seizures	☐	☐	Kidney Disease
☐	☐	Autism	☐	☐	Diabetes	☐	☐	Leukemia
☐	☐	Bladder Problems	☐	☐	Emotional Disability	☐	☐	Mental Handicap
☐	☐	Blood Transfusions	☐	☐	Epilepsy	☐	☐	Nutritional Deficiency
☐	☐	Birth Defects	☐	☐	Eye Problems	☐	☐	Premature Birth
☐	☐	Bone / Joint Problems	☐	☐	Excessive Bleeding/Hemophilia	☐	☐	Rheumatic Fever
☐	☐	Brain Injury	☐	☐	Fainting or Dizziness	☐	☐	Scoliosis
☐	☐	Bruising Easily	☐	☐	Gastrointestinal Disorders	☐	☐	Sickle Cell Disease or Trait
☐	☐	Cancer or Malignancies	☐	☐	Growth / Development Problems	☐	☐	Spina Bifida
☐	☐	Cerebral Palsy	☐	☐	Hearing / Speech Problems	☐	☐	Syndrome: _____
☐	☐	Child Abuse (physical or sexual)	☐	☐	Hepatitis / Liver Disease	☐	☐	Tuberculosis
☐	☐	Chronic Adenoid / Tonsil Infection	☐	☐	Heart Disease / Malformation	☐	☐	Other: _____
☐	☐	Chronic Headaches	☐	☐	Heart Murmur			_____

- If you answered YES to any of the above, please explain: _____

- Please make us aware of current medical issues including medications, pending surgery, recent injuries, or any other information we should know about your child: _____

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DENTAL HEALTH HISTORY

- How do you expect your child to react to the visit today? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
- Please check any of the following which describe your child: ☐ shy ☐ stubborn ☐ anxious ☐ frightened ☐ moody ☐ friendly ☐ outgoing ☐ cooperative ☐ suspicious
- When does your child brush (check all that apply)? ☐ A.M. ☐ P.M. ☐ After snacking / eating
  - Does an adult assist with brushing? ☐ Yes ☐ No When? _____
  - Do you or your child use dental floss in cleaning his/her teeth? ☐ Yes ☐ No
- Does your child receive fluoride in any of the following forms?
  - Fluoride tablets or fluoride multivitamins: ☐ Yes ☐ No Dosage: _____ mg/day
  - Water supply (either well or city water): ☐ Yes ☐ No
  - Toothpaste: ☐ Yes ☐ No
  - Rinse/Gel ☐ Yes ☐ No
- Please let us know if your child has any oral habits: ☐ Bottle or sippy cup usage ☐ Thumb/finger sucking ☐ Pacifier ☐ Mouth breathing ☐ Teeth grinding ☐ Lip sucking
- Your child was nursed until age: _____ • Your child was bottle fed until age: _____
- Has your child had any injuries to the teeth, mouth or jaws? ☐ Yes ☐ No
  - Explain (age, teeth involved, cause of injury, treatment received): _____
  _____
- How may we make this visit a positive experience for your child? _____

My signature below (as the parent or guardian) authorized the completion of all agreed upon dental services for my child. In addition, I certify that the above information is complete and accurate, to the best of my knowledge.

_____	_____	___/___/___
Signature of parent/guardian	Relationship to patient	Date

Thank you for filling out this form completely; your cooperation will enable us to help your child more effectively. If you have any questions, please ask us. We appreciate your confidence in choosing our office and we look forward to an ongoing relationship. Our office commits to meeting and exceeding the standards mandated by OSHA, HIPAA, the CDC and the ADA.