WELCOME
KIDS DDS

ABOUT YOUR CHILD

CHILD'S NAME (First) (MI) (Last)

NAME CHILD PREFERS TO BE CALLED M ❑ F ❑

AGE WEIGHT HEIGHT DATE OF BIRTH

REASON FOR VISIT

How did you find out about this office?

(1) REFERRED BY (We wish to thank them):

FULL NAME PHONE #

(2) OTHER: ____

DENTAL HISTORY

CHILD'S FIRST DENTAL VISIT? YES NO

PREVIOUS DENTIST CITY

DATE OF LAST VISIT

Any injuries to your child's teeth or jaws? YES NO

WHEN?____________________________

HISTORY OF:	PAST	PRESENT
Nursing bottle habits		
Thumb sucking /finger sucking		
Pacifier		
Teeth grinding or clenching		

Has your child experienced any unfavorable reaction from previous Medical or dental care? ❑ YES ❑ NO If yes, please explain:

How do you think your child will act toward the dentist?

MEDICAL HISTORY

Is your child presently under the care of his/her pediatrician for any medical reason? If yes, what?____________________ ❑ YES ❑ NO

PHYSICIAN'S NAME PHONE #

STREET ADDRESS CITY ZIP

Is your child currently under the care of a specialist for any medical reason? If yes, what? ____________ ❑ YES ❑ NO

SPECIALIST'S NAME PHONE #

STREET ADDRESS CITY ZIP

Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt, or other medical reason? ❑ YES ❑ NO

Is your child presently taking any prescription or over-the-counter medication? If yes, what? ❑ YES ❑ NO

Has your child had a history of taking medications frequently? Which ones? ______________________ ❑ YES ❑ NO

Does your child take prescription fluoride, in drops or tablets? ❑ YES ❑ NO

Has your child ever been hospitalized or had surgery? For what? ____________________________________ ❑ YES ❑ NO

Is your child allergic to any drug or medication? ❑ YES ❑ NO
If yes, what?_____________________________________
If yes, what were the symptoms of the allergic reaction?

Is your child allergic to any dyes? ❑ YES ❑ NO
If yes, what colors? _____________________________

Is your child allergic to any environmental pollutants? ❑ YES ❑ NO
If yes, what? ___________________________________

Is your child allergic to any foods? ❑ YES ❑ NO
If yes, what? ___________________________________

Is your child allergic to any latex, metals or acrylics? ❑ YES ❑ NO
If yes, what? ___________________________________

Does your child's skin react to adhesive bandages, snaps on clothes, or costume jewelry? ❑ YES ❑ NO

Has any member of the family, including your child, had a problem with a general anesthetic? ❑ YES ❑ NO

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MEDICAL HISTORY (Cont'd)

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK YES OR NO:

Y N
- ❑ ❑ AIDS / HIV
- ❑ ❑ Anemia
- ❑ ❑ Arthritis
- ❑ ❑ Asthma. If yes, what triggers it? ____________________
- ❑ ❑ Autism
- ❑ ❑ Bladder Conditions
- ❑ ❑ Blood Disease
- ❑ ❑ Blood Transfusions
- ❑ ❑ Birth Defects
- ❑ ❑ Bone or Joint Problems
- ❑ ❑ Brain Injury
- ❑ ❑ Bruising Easily
- ❑ ❑ Cancer or Malignancies
- ❑ ❑ Cerebral Palsy
- ❑ ❑ Chemotherapy Radiation
- ❑ ❑ Child Abuse
- ❑ ❑ Chronic Adenoid / Tonsil Infection
- ❑ ❑ Chronic Ear Infections
- ❑ ❑ Chronic Headaches
- ❑ ❑ Cleft Lip / Palate
- ❑ ❑ Congenital Heart Lesion
- ❑ ❑ Convulsions / Seizures
- ❑ ❑ Developmentally Delayed
- ❑ ❑ Diabetes
- ❑ ❑ Drug Addiction
- ❑ ❑ Emotional Disturbance
- ❑ ❑ Epilepsy
- ❑ ❑ Eye Problem

Y N
- ❑ ❑ Excessive Bleeding Problem
- ❑ ❑ Excessive Gagging
- ❑ ❑ Fainting or Dizziness
- ❑ ❑ Fever Blisters
- ❑ ❑ Growth & Developmental Problems
- ❑ ❑ Heart Surgery
- ❑ ❑ Hearing / Speech Impairments
- ❑ ❑ Heart Murmur / Defect
- ❑ ❑ Hemophilia
- ❑ ❑ Hepatitis or Liver Disease
- ❑ ❑ High Blood Pressure
- ❑ ❑ Hyperactivity / ADD
- ❑ ❑ Kidney Disease
- ❑ ❑ Leukemia
- ❑ ❑ Mental Disability
- ❑ ❑ Mouth Sores (Canker Sores)
- ❑ ❑ Nutritional Deficiency
- ❑ ❑ Orthopedic Problems
- ❑ ❑ Pain, Popping, Clicking of Jaw Joints
- ❑ ❑ Premature Birth
- ❑ ❑ Psychiatric Care
- ❑ ❑ Rheumatic Fever
- ❑ ❑ Scoliosis
- ❑ ❑ Sickle Cell Anemia
- ❑ ❑ Syndrome: ____________________
- ❑ ❑ Tuberculosis
- ❑ ❑ Other ____________________
- ❑ ❑ Do you wish to talk to the doctor privately about a special concern?

RESPONSIBLE PARTY

(*Must be completed to accept insurance assignment.*)

FATHER'S FULL NAME

ADDRESS

CITY | STATE | ZIP

SOCIAL SECURITY # | BIRTHDATE

HOME PHONE # | BUSINESS PHONE #

EMPLOYER | OCCUPATION

MOTHER'S FULL NAME

ADDRESS

CITY | STATE | ZIP

SOCIAL SECURITY # | BIRTHDATE

HOME PHONE # | BUSINESS PHONE #

EMPLOYER | OCCUPATION

CHILD LIVES WITH: BOTH PARENTS   MOTHER   FATHER   OTHER

Names of siblings who are patients here: ____________________

____

INSURANCE

PRIMARY INSURANCE | GROUP #

POLICIY HOLDER NAME

SECONDARY INSURANCE | GROUP #

POLICY HOLDER NAME

AUTHORIZATION

I understand that I am responsible for all charges incurred by me and my family regardless of insurance coverage and that PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for the collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to Lisa J. Stimmel DDS, MS, P.C. on any unpaid bills for services furnished me or my family. I authorize the release of any dental information necessary to process this claim and all future claims. The policy in our office is such that the parent or guardian who requests treatment for a child is responsible for all fees for services rendered.

SIGNATURE

DATE

THE PERMISSION OF PARENT OR GUARDIAN IS NECESSARY FOR DENTAL TREATMENT OF A MINOR

I give the doctor permission to use such measures as deemed necessary in her professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (X-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any proper allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

SIGNATURE

RELATIONSHIP TO CHILD

DATE

TO BE COMPLETED BY DOCTOR

REVIEWED BY: DOCTOR | DATE