madisonkidsdentist.com

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About Your Child

Child's Name: ______________________________

Nickname: ____________________ ☐ Female ☐ Male

Child's Birthdate: ___/___/___ Age ____

SS#/Ins. ID______________________________

Does child live with ☐ Both Parents ☐ Mom ☐ Dad ☐ Guardian ☐ Foster Parents ☐ Stepmother ☐ Stepfather ☐ Other

Child's Address: ______________________________

City ________________ State ____ Zip ________

If child does not live with both parents please provide addresses of both parents.

Mom: ______________________________

____

Dad: ______________________________

____

Who is Accompanying the Child Today?

Name: ______________________________

Relation to Child: ______________________

Name of person with legal custody of the child?

____

Whom may we thank for referring your child?

____

Other family members seen by us:

____

____

Legal Guardian

Mother's Name: ______________________________ DOB ____/____/____

Mother's Employer:______________________________ SS#/Ins. ID ____________________

Father's Name: ______________________________ DOB ____/____/____

Father's Employer:______________________________ SS#/Ins. ID ____________________

Dental Insurance

Do you have dental insurance? Yes ☐ No ☐

Primary insurance co. name, address, phone.

____

____

Subscriber for primary insurance is Mom ☐ Dad ☐ Other ☐

If other is checked provide us with their name, relationship to patient, social security #, employer and birthdate.

____

____

Secondary insurance co. name, address, phone.

____

____

Subscriber for secondary insurance is Mom ☐ Dad ☐ Other ☐

If other is checked provide us with their name, relationship to patient, social security #, employer and birthdate.

____

____

Do you have Wisconsin Medical Assistance? ☐ Yes ☐ No

If you have WI Medical Assistance, you are required to bring your child's card to each appointment.*

Telephone Numbers

Home: ______________________________

Cell # ______________________________

E-Mail Address ______________________________

Mom's Work # ______________________________

Dad's Work # ______________________________

Emergency Contact # ______________________

Name ______________________________

Relation ______________________________

Please Complete Backside

Dental History

Any current dental complaints? ____

____

Has the child ever had a problem associated with previous dental work? ☐ Yes ☐ No Specify if yes: ________________

____

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoride supplement? ☐ Yes ☐ No If yes, what? ______________________

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Is this your child's first dental visit? ☐ Yes ☐ No

If no, who was the last Dentist? ______________________ Last visit date: ________________

Oral Habits *(please indicate any history)*

Currently using bottle? Y N

If no, what age discontinued. _____

Currently breastfeeding? Y N

If no, what age discontinued. _____

Y N Thumb/Finger Sucking

Y N Nail Biting

Y N Lip Sucking/Biting

Y N Speech Impairment

Specify if yes to any questions

____

____

____

Has the child ever had the following medical problems?

Please indicate any history of the following and write in detail (dates, etc.) below:

Y N ADD/ADHD
Y N Heart Murmur
Y N Cancer
Y N Diabetes
Y N Rheumatic Fever
Y N Physical or psychological development delay

Y N HIV+/AIDS
Y N Hemophilia
Y N Asthma
Y N Hepatitis
Y N Tuberculosis

Y N Anemia
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Abnormal Bleeding
Y N Hearing Impairment
Y N Any Operations

Y N Shunts
Y N Any stays in a hospital
Y N Kidney/Liver Problems
Y N Handicaps/Disabilities
Y N Allergies
Y N Other ________________

Please discuss any medical problems the child has had: ______________________________

____

Child's Physician: ______________________ Phone #: ________________ Last Visit Date: __________

Any current medical complaints? ____

____

Please list all drugs the child is currently taking: ______________________________

____

Please list all drugs/latex that the child is allergic to: ______________________________

____

I understand the information I have given is 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 the dental staff to perform the necessary dental services my child may need. I accept full responsibility for full payment of the treatment performed. It is my understanding that two (2) consecutive broken appointments without explanation may lead to dismissal of my child as a clinic patient.

Signature ______________________________________ Date ____________________

Relationship to child ____

FINANCIAL POLICY

Payment is due when services are rendered. We accept cash, personal checks and all major credit cards. We realize that some procedures are more extensive than other and we will be more than willing to work out alternative financial arrangements prior to treatment. I understand and agree that, (regardless of my insurance status or marital status), I am ultimately responsible for the balance on this account for any professional services rendered.

I have read the above information and understand my obligations.

Signature of financially responsible party ______________________________________