

to our Practice!



We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PATIENT INFORMATION

Name	Nickname		Home Phone	
Address				
CityState	Zip	Child's	Physician	
Sex M DF Age	Birth Date	Physic	ian's <mark>Phone</mark>	
Soc. Sec. #	School	Δ.	Grade	
PAR	ENT/GUARDIAN	INFORM	ATION	
☐ Mother ☐ Stepmother	☐ Guardian	7 Father	☐ Stepfather ☐ Guard	ian
Name		Name	0.00	
E-mail 5		-mail	9 (8%)	
Work Phone		Vork Phone	1900	
Cell Phone		ell Phone	10.5	
Soc. Sec. #Birt	h Date	oc. Sec. #_	Birth Date	
Employer	E	mployer		
Occupation		Occupation		
DEN	TAL INSURANCE	E INFORM	MATION	
Subscriber's Name		Soc. Sec	#	
Insurance Company	11	Group #	402155.0	
Insurance Claims Address	Cit	/	State Zip	

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. If there is any change in my child's medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by the insurance company.





Dakota Kids Dentistry







Health History



Has your child had any difficulty	with prev	vious visits?	Is your child being treated by a physician	at this time?		
Comments:			If so, why?			
Has your child ever had any of the following:			Is your child allergic to anything: (medicine, food, other)?			
Asthma	yes	no	If yes, what?			
Diabetes	☐ yes	no	Is your child taking any medicines at this time?			
Seasonal Allergies (ie: Hayfever)	yes 🗍	no no	If so, what?			
Allergies (ie: medicines/food/other)	yes	no no	How often does your child brush?			
Cancer/Hepatitis	yes	no	How often does your child floss?			
Cleft Lip/Palate	yes	no	Previous DentistWhen			
HIV/AIDS	☐ yes	☐ no	Is your child's water fluoridated?	ges no		
Hemophilia	☐ yes	no	Does your child take fluoride supplements? 🗌 yes 🗍			
Autism	☐ yes	no	Does your child suck thumb/pacifier?	yes no		
Rheumatic Fever	yes	no	Does your child bite/chew nails or	yes no		
Congenital Heart Defect	yes	no	hard objects?	yes no		
Handicaps/Disabilities	☐ yes	no				
Convulsions/Epilepsy	☐ yes	no				
Tuberculosis	yes	no				
Abnormal Bleeding	☐ yes	no				
MRSA (Methicillin-resistant Staphylococcus aureus)	☐ yes	□ no	Dentist's Review			
Heart Murmur	☐ yes	☐ no	A CONTRACTOR			
Туре	> W	- 11 -	A A L			
Please explain any medical prob	lems that	your child	William Street William Co.			
has or had:	0	65				
			DateSigned Dr			

We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits, which will help keep their smile beautiful for their lifetime. We invite parents to accompany children into the examination area for their first visit. However, as a general office policy, we prefer that parents wait in the waiting room if children have to come back for treatment.







