# Kids First Dental Medical History

Child's Name:_____ Cell Phone #:_____
Date of Birth:_____ Sex: ___M ___F Siblings seen here:_____
Home Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____
Child's Physician: _____ Phone #: _____
Physician Address: _____
Is the child currently being treated for any condition? __Y __N Please explain: _____

Does your child have any allergies to the following?
☐ Pollen ☐ Latex ☐ Dust ☐ Food ☐ Food Dye ☐ Other: Please explain

_____

List all medication the child is currently taking: _____
List any medication(s) that cause the child allergic reactions: _____

**Please check any that pertain to your child**

☐ Abnormal Bleeding
☐ Aids/HIV*
☐ Anemia
☐ Attention Deficit Disorder/ADHD
☐ Asthma
☐ Autism
☐ Any hospital stay/surgery
☐ **ANY HEART CONDITION***
☐ Blood Transfusion*
☐ Cancer
☐ Cerebral Disorders
☐ Chicken Pox
☐ Convulsions
☐ Diabetes
☐ Seizure Disorder/Epilepsy*
☐ Hearing Impairment
☐ Hemophilia*
☐ Hepatitis (A, B or C)*
☐ High Blood Pressure
☐ Hives
☐ Kidney Problems
☐ Liver Problems
☐ Low Blood Pressure
☐ Lupus
☐ Measles
☐ Mitral Valve Prolapse*
☐ Mononucleosis
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sickle Cell Anemia*
☐ Skin Rash
☐ Tonsillitis
☐ Tuberculosis*
☐ Excessive Gagging
☐ Fainting or Dizziness
☐ Prosthetic Joints*
☐ Sickle Cell Trait

*** Indicates we will need medical clearance from doctor's office or pre-medication is required before appointment.**

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information that has not been covered above:

_____
_____

## Dental History

What is the primary reason for today's visit? _____
Is the child currently in pain: __Y __N Has the child ever had any pain/tenderness in his/her jaw joint? __Y __N
Has the child ever had any injuries to his/her teeth, mouth, head or jaw? __Y __N If yes, describe: _____
Has the child ever experienced problems with previous dental work? _Y _N If yes, explain: _____
Is the child's water fluoridated? __Y __N Is the child taking fluoridated supplements? __Y __N
Brush his/her teeth daily? __Y __N Does an adult assist with brushing? __Y __N
Floss his/her teeth daily? __Y __N Does an adult assist with flossing? __Y __N

**Does/did the child have any of the following habits?**

Y N Lips sucking/biting
Y N Nail biting
Y N Mouth Breather
Y N Clenching/grinding teeth
Y N Used pacifier until age ___
Y N Nursing bottle habits until age ___
Y N Thumb/finger sucking until age ___
Y N Tongue/cheek biting
Y N Tongue thrust

*I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform necessary dental services my child may need.

Signature _____ Date _____

# Welcome to Kids First Dental

Children's Names_____

**Parent #1 Information**

__Mother __Father __Stepmother __Stepfather __Grandmother __Grandfather __Guardian

Name:_____ Date of Birth:_____

Home Address:_____ City:_____ State:_____ Zip_____

Home Phone:_____ Cell Phone:_____ Work:_____

May We Contact You At Work? __Y __N Occupation:_____ SSN:_____

Employer's Name_____

E-Mail Address:_____

Emergency Contact Name:_____ Relationship to Patient:_____ Phone Number:_____

**Parent #2 Information**

__Mother __Father __Stepmother __Stepfather __Grandmother __Grandfather __Guardian

Name:_____ Date of Birth:_____

Home Address:_____ City:_____ State:_____ Zip_____

Home Phone:_____ Cell Phone:_____ Work:_____

May We Contact You At Work? __Y __N Occupation:_____ SSN: _____

E-Mail Address:_____

Employer's Name_____

Emergency Contact Name:_____ Relationship to Patient:_____ Phone Number:_____

**Responsible Party**

The responsible party on your child's account is the parent who most commonly brings your child(ren) for their regular dental visits. This person will receive most of the information from our office regarding preventative care, diagnosis proposed treatment and will thus make decisions which best suits your family's dental needs. This person is also the contact for your child(ren). Please list the name of the responsible party for your family.

Responsible Party Name:_____ Relationship to Patient:_____

Date of Birth:_____ Sex: __M __F Day Time Phone Number:_____

Address:_____ City:_____ State:_____ Zip:_____

How Did You Hear About Us?Friend (Name)_____ __Sign __Flyer __Internet __Radio (staion)_____ __TV Commercial

# Kids First Dental

## NAME OF PRACTICE

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**I, _____, have received a copy of this office's Notice of Privacy Practices.**

**Print Patient's Name: _____**

**Please list any individuals that may bring your child/children to the dentist in the future.**

**_____**

**_____**

**Signature: _____**

**FOR OFFICE USE ONLY**

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:**

- **Individual refused to sign.**
- **Communication barriers prohibited obtaining the acknowledgement.**
- **An emergency situation prevented us from obtaining the acknowledgement.**
- **Other (please specify).**