WELCOME TO OUR OFFICE

Child's Information (Patient)

Name ______________________________ Nickname ______________________________

Address ______________________________ Birthdate ____________________ Sex ________

City/State/Zip ______________________________ School ______________________________

Chief Complaint ____

Whom may we thank for referring you to our office? ________________________________

Father/Guardian/Stepfather (circle one)

Name ______________________________

Address ______________________________

City/State/Zip ______________________________

Home Phone (_____)______________________________

Cell Phone (_____)______________________________

Employer ______________________________

Business Phone if OK to call (_____)____________________

Social Security # ______________________________

Email ______________________________

Mother/Guardian/Stepmother (circle one)

Name ______________________________

Address ______________________________

City/State/Zip ______________________________

Home Phone (_____)______________________________

Cell Phone (_____)______________________________

Employer ______________________________

Business Phone if OK to call (_____)____________________

Social Security # ______________________________

Email ______________________________

Person responsible for the account: ____

Emergency Information: If we are unable to contact the parent, whom should we contact?
(DO NOT LIST YOURSELF OR SPOUSE)

Name ____________________ Relationship ____________________ Phone ____________________

INSURANCE INFORMATION

Primary Dental Insurance

Cardholder Name ______________________________

Employer ______________________________

Ins. ID # ______________________________

Date of Birth ______________________________

Insurance Co. ______________________________

Secondary Dental Insurance

Cardholder Name ______________________________

Employer ______________________________

Ins. ID # ______________________________

Date of Birth ______________________________

Insurance Co. ______________________________

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or that of anyone for whom I have aurthorized treatment.

____

**** SIGNATURE OF PATIENT OR PARENT IF MINOR** **DATE**

WENDY K. HUMPHREY, D.M.D.
JULIETTE KELLER, D.M.D.
PEDIATRIC DENTISTRY
2201 REGENCY ROAD SUITE 503
LEXINGTON, KY 40503
859-277-5437

MEDICAL-DENTAL HISTORY

Name ______________________________ Nickname ____________________ Sex ________

Birthdate ______________ Age ____ Child's Physician ____________________ Date Last Seen ________

Physician's Address ______________________________________ Phone ________________

Date of Last Physical Exam ____________________ Are immunizations up to date? ________________

1. Condition of your child's health ____
2. Has your child recently undergone or is she/he undergoing any medical treatment? ________________
3. Has your child ever been hospitalized, had an operation or been confined to bed for a long period of time? ____________

   ____
4. Is any medical treatment anticipated in the future? ______________________________
5. Does your child have any allergic reactions to any kind of medicine, latex or food? ________________
6. Is your child presently taking any kind of medication? ______________________________

   If yes, please list medication and dosage. ______________________________________
7. Does your child have any unusual fears? ______________________________________
8. Does your child have any history of :

_____ Allergies	_____ Brain Injury	_____ Autism/Ausbergers'
_____ Anemia	_____ Cancer	_____ ADHD
_____ Asthma	_____ Cerebral Palsy	_____ Downs Syndrome
_____ Excessive Bleeding	_____ Diabetes	_____ Mental/Emotional Problems
_____ Hemophilia	_____ Epilepsy/Seizures	_____ Heart Disease
_____ HIV/AIDS	_____ Liver Disease/Hepatitis	_____ Heart Murmur:
_____ Sickle Cell Anemia	_____ Kidney Problems	___ Active ___ Functional
_____ Tuberculosis		_____ High Blood Pressure
		_____ Rheumatic Fever

   Other (please specify) ____
9. Has your child ever had any hearing, sight, speech, or coordination problems? ________________

   ____
10. Is there any additional medical information we should know? ______________________________

    ____
11. Is this the first time your child has visited a dental office? Yes No
12. If not, how long since his/her last visit to the dentist? ______________________________

13. If your child has previously been to the dentist, did he/she receive any of the following:

_____ Local anesthetic (Novocain) _____ X-rays _____ Sedation

_____ Nitrous Oxide Analgesic (Laughing Gas) _____ General Anesthetic

Were there any unfavorable reactions? ______________________________

14. Were there any acute dietary or medical problems during pregnancy such as : Measles, sickness with high fever, blood disorders (anemia), others? (please skip to question #15, if your child was adopted) ______________________________

____

15. Does your child have a history of:

_____ Thumb Sucking _____ Tongue thrusting _____ Lip or nail biting

_____ Pacifier _____ Mouth Breathing _____ Object biting

16. Has there been any injury to your child's teeth by a fall, blow, bump, or otherwise? ______________________________

____

17. Up to what age was your child using the night bottle or breast-fed? ______________________________

18. Does your child use a sippy cup? Yes ____ No ____ How often ______________________________

19. How often does your child brush his/her teeth? ______________________________

20. Does your child consume excessive amount of any of the following:

____ Milk ____ Juice ____ Candy ____ Well Water ____ Bottled Water ____ Soda Pop

21. Is your child receiving fluoride supplements? Yes ____ No ____

22. Does your child drink? ____ City Water ____ Well Water ____ Bottled Water ____ Filtered Water

23. Has your child ever complained of:

_____ Toothache _____ Jaw joint sounds or pain _____ Frequent headaches

_____ Teeth sensitive to heat _____ Teeth sensitive to cold _____ Pain in ear

24. Are you concerned about any special dental problems now? ______________________________

____

25. Reason for seeking treatment at this time? ______________________________

____

26. Do you expect your child to be uncooperative? (if yes, please explain) ______________________________

____

Thank you for completing this personal history. The information which you supplied allows us to plan for your child's emotional and dental needs while making a thorough evaluation of his/her dental health.

The above statements are, to the best of my knowledge, true and correct. I authorize the treatment of this patient.

____

Signature of Parent or Guardian **Relationship to Patient** **Date**