Welcome

Please take a few minutes to fill out the questionnaire so we can best serve your needs. Thank you very much for your attention.

Child's Name____Nickname ________________
Last First Middle Initial
Date of Birth _______________ Age______ Sex________ Social Security Number _____________
Address ____________________________________City _____________State _____ Zip_______
Parent/Legal Guardian's Name ____
Home Phone () _________________________Parent's Work Phone () ____________________
Parent's Cell phone () ______________________**E-mail**___________________________________

○ Please mark this box, if you **DO NOT** want to be receiving text messaging through your cell phone

Primary Insurance(Leave blank only if no dental benefits)
Subscriber__________________ Relationship________
Date of birth ____________SS Number ____________
Address (if different)___________________________
City____________________ State_____ Zip______
Phone ( )___________ Cell Phone ( )___________
Insurance Company_____________________________
Address ___________________Phone_____________
City ____________________ State_____ Zip______
Contract# ______________ Group# ______________
Subscriber#______________
Other Dependents covered under this plan
____

Secondary Insurance
Subscriber__________________ Relationship________
Date of birth ____________SS Number ____________
Address (if different)___________________________
City____________________ State_____ Zip______
Phone ( )___________ Cell Phone ( )___________
Insurance Company_____________________________
Address ___________________Phone_____________
City ____________________ State_____ Zip______
Contract# ______________ Group# ______________
Subscriber#______________
Other Dependents covered under this plan
____

In case of emergency, contact _________________________________ Phone ( ) _______________________

Informed Consent

How did you hear about our office?____

I hereby authorize the dentists and staff at Star Kids Dental & Orthodontics to perform diagnostic aids including x-rays, models and photographs as appropriate to make a thorough diagnosis of my child's dental needs.

I authorize my insurance company to pay the dentist(s) 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(s) 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 insurance.

☐ **I am not legal guardian, but I have permission from the legal guardian to authorize Star Kids Dental & Orthodontics to perform any dental care as needed.**

_________________________ _______________ _____________________ _______________
Signature **Date** **Dentist Signature** **Date**

Payment is due in full at time of treatment unless prior arrangements have been approved.

Dental History

Reason for Today's Visit ____

Is this your child's first visit to the dentist? Yes / No

If not, Former Dentist ___________________________________ Phone ______________________________

Address ____Reason for leaving _____________________

Date of Last Dental Care ___________________________ Date of Last X-rays ____________________

Does your child have any of the following?

Sensitivity to heat	Yes / No	Sores or growths in the mouth	Yes / No	Grinding teeth	Yes / No
Sensitivity to cold	Yes / No	Bad Breath	Yes / No	Bleeding gums	Yes / No
Sensitivity to biting	Yes / No	Loose teeth/Broken fillings	Yes / No	TMJ Disorder	Yes / No
Sensitivity to sweet	Yes / No	Swelling in the face	Yes / No	Clicking jaws	Yes / No

How often does your child brush? ______________ how often does your child floss? ___________________

Is your child nervous towards previous dental treatment? If yes, describe ____

Do you have any particular concerns regarding your child's dental care? _______________________________________

Has your child or any member in your family had orthodontic treatment (braces)? Yes / No

Medical History

Physician's Name __________________________ Date of Last Visit _________

Was your child a patient in a hospital? Yes / No

If so, describe ____

Is your child now under medical care? Yes / No

Is your child taking any medications now? Yes / No

If so, describe____

Has your child ever had a serious illness or operation? Yes / No

If so, describe ____

Is your child allergic to any medicine or anesthetic? Yes / No

If so, describe ____

Does your child have any of the following conditions?

Heart Trouble	Yes / No	Kidney Problems	Yes / No	Venereal Disease	Yes / No
Heart Attack	Yes / No	Hepatitis	Yes / No	AIDS/HIV	Yes / No
Coronary Insufficiency	Yes / No	Jaundice	Yes / No	Thyroid Disease	Yes / No
Coronary Occlusion	Yes / No	Liver Disease	Yes / No	Nervous Disorder	Yes / No
High Blood Pressure	Yes / No	Tuberculosis	Yes / No	ADD/ADHD	Yes / No
Arteriosclerosis	Yes / No	Lung Problems	Yes / No	Autism	Yes / No
Stroke	Yes / No	Persistent Cough	Yes / No	Seizures/Fainting Spells	Yes / No
Mitral Valve Prolapse	Yes / No	Emphysema	Yes / No	Epilepsy	Yes / No
Heart Murmur	Yes / No	Sinus Problems	Yes / No	Cerebral Palsy	Yes / No
Rheumatic Heart Disease	Yes / No	Stomach Ulcers	Yes / No	Mental Disability	Yes / No
Sickle Cell Disease	Yes / No	Diabetes	Yes / No	Hearing Disability	Yes / No
Bleeding Disorder	Yes / No	Inflammatory Rheumatism	Yes / No	Developmental Disability	Yes / No
Excessive Bleeding	Yes / No	(painful/swollen joints)	Yes / No	Cleft Lip/Palate	Yes / No
Anemia	Yes / No	Arthritis		Premature Birth	Yes / No
Congenital Heart Disease	Yes / No	Asthma	Yes / No	How many weeks? ____	Yes / No
PenicillinAllergy	Yes / No	Hives/Rashes	Yes / No		
Latex Allergy	Yes / No				

Does your child have any conditions not mentioned above? If so, what: ___________________________________

Adolescent Women:

Are you pregnant now or think you may be? Yes / No

Are you nursing? Yes / No

Are you taking oral contraceptive? Yes / No

___________________________________ ___________________________________ _____________________

Name of parent/legal guardian (please print) **Signature** **Date**

___________________________________ ____

Review Medical History/Comments **Dentist Signature** **Date**