KIMBERLY D. THIEL, D.D.S.

Practice Limited to Children

CHILD'S HISTORY

Your child's overall health, as well as any medications which your child takes, could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Has your child ever had any of the following medical problems?

Y N	ADD/ADHD	Y N	Heart murmur
Y N	Allergies to any drugs	Y N	Hemophilia
Y N	Asthma	Y N	Hepatitis
	Y N Inhaler carried	Y N	HIV+/Aids
Y N	Cancer	Y N	Kidney/liver problems
Y N	Congenital heart defect	Y N	Latex allergy
Y N	Convulsions/epilepsy	Y N	Rheumatic fever
Y N	Diabetes	Y N	Severe food allergies
Y N	Handicaps/disabilities	Y N	Tuberculosis (TB)
Y N	Hearing impairment		

Child's Physician: _____

Phone: _____ Date of last visit: _____

Reason: _____

Please list all drugs that your child is currently taking: _____

_____

Please list any allergies: _____

_____

Child ever been hospitalized? _____ When? _____

Why? _____

Please explain any medical problems that your child has: _____

_____

_____

Does your child have any limiting mental or emotional problems?

Why did you bring your child to the dentist today?

_____

_____

Has your child ever had a serious/difficult problem associated with previous dental work? _____

_____

_____

Previous/Present Dentist: _____

Date of last visit: _____

Whom may we thank for referring him/her: _____

_____

Are there any questions you have regarding your child's dental development or care? _____

_____

_____

Does your child have or do any of the following?

❑ Clench/grind	❑ Pacifier habit
❑ Speech problems	❑ Breast feed
❑ Thumb/finger habit	❑ Baby bottle/sippy cup

Does your child receive fluoride in any of these forms?

❑ Prescribed tablets/liquid	❑ Fluoridated water
❑ Fluoride rinse	❑ Fluoride toothpaste

Please list all of your children below

_____ Age ____	_____ Age ____	_____ Age ____
_____ Age ____	_____ Age ____	_____ Age ____

I understand that the information that I have given is correct 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 childs medical state. I also understand that insurance claims are sent electronically. CONSENT: the signature of the parent or guardian below authorizes the completion of all agreed upon dental services and the use of those methods and techniques appropriate thereto. This consent shall remain in full force and effect until cancelled by either party on behalf of:

Child's name _____

By _____ Relationship _____

Date _____ 20

General Information

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: _____ / _____ / _____ Child's Age: _____

Nickname: _____ ❑ Male ❑ Female

School: _____ Grade: _____

Child's SS#: _____

Child's Home Address: _____
Apt / Condo #

_____
City State Zip

Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Is the child adopted? ❑ Yes ❑ No

Is the child in a foster home? ❑ Yes ❑ No

Parent's Marital Status: ❑ Single ❑ Widowed ❑ Remarried
❑ Married ❑ Divorced ❑ Separated

Name, address and phone number of relative not living with you:

_____

_____

Name, address and phone number of friend or neighbor to notify in case of emergency: _____

_____

Parent's Information

Mother ❑ **Step-Mother ❑** **Guardian ❑**

Name: _____

Birthdate: _____ SS#: _____

Address: _____

_____
City State Zip

Home Phone: _____ D/L#: _____

Employer: _____

Address: _____

_____
City State Zip

Work Phone: _____ Cell Phone: _____

Occupation: _____

Father ❑ **Step-Father ❑** **Guardian ❑**

Name: _____

Birthdate: _____ SS#: _____

Address: _____

_____
City State Zip

Home Phone: _____ D/L#: _____

Employer: _____

Address: _____

_____
City State Zip

Work Phone: _____ Cell Phone: _____

Occupation: _____

I understand that I am responsible for payment of services rendered and/or responsible for paying any dental insurance co-pay and deductible at the time of service. For those covered by dental insurance, we wish to assure you that we will do everything possible to help you obtain the benefits to which you are entitled, however, we need to inform you that any fees incurred are your personal responsibility regardless of insurance.

Signature: _____ **Date:** _____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone: ( ) _____

Group Number (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____ / ____ / ___ SS#: _____

Policy Owner's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone: ( ) _____

Group Number (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____ / ____ / ___ SS#: _____

Policy Owner's Employer: _____

Employer's Address: _____

_____
City State Zip