MIDLAND KID'S DENTIST

TODDLERS ★ ADOLESCENTS ★ TEENS

Please Take a Few Minutes to answer the following question so we Can better assist you with your Dental Needs.

Date: ____ / ____ / _____

Patient Information

Name: _____ Nickname _____

Last Name First Name Middle Initial

Address: _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ D.O.B: _____ / _____ / _____

Social Security # _____ - _____ - _____ Sex: ☐ M ☐ F

Grade _____ School/Daycare _____

Name/Ages of other Children in Family: _____

How Did You Hear About Us?

☐ Radio ☐ Television ☐ Insurance

☐ Internet ☐ Personal Reference ☐ Walk-In

☐ Phonebook ☐ Local event _____ ☐ Other _____

In case of emergency who should we contact? _____ Phone _____

Person Responsible for account _____

Primary Dental Insurance

PRIMARY INSURED'S INFORMATION ONLY REQUIRED BELOW

Name _____

Last Name First Name Middle Initial

Relationship to Patient _____ D.O.B: _____ / _____ / _____

Social Security # _____ - _____ - _____ Contact Phone Number _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Employer _____

Insurance Company _____ Phone Number _____

Subscriber ID # _____ Group # _____

Medicaid ID # _____ Carrier: TMHP / DentaQuest / MCNA Dental

Chip ID # _____ Carrier: TMHP / DentaQuest / MCNA Dental

Guardian Signature _____ Date _____ / _____ / _____

Health History

Your child's overall Health as well as any Medications which your Child takes could have an important role with the Dental Care He/She receives. Please Answer the following questions accurately and Completely:

Has your Child been to the Dentist Before: Yes ☐ No ☐ How would you rate your Child's experience at the previous Dentist? GOOD ☐ BAD ☐

How often does your child brush their teeth? _____ Floss? _____

Does your child take Fluoride Supplements? _____

Please Mark "YES" or "NO" for the following Questions regarding your child:

YES	NO		YES	NO	
☐	☐	Sucks Fingers/Thumb	☐	☐	Chews on hard Objects (Pencils, ETC.)
☐	☐	Sucks/Bites Lips	☐	☐	Grinds Teeth
☐	☐	Bites/Chews Nails	☐	☐	Clenches Jaws

Please Mark Below if Applicable:

☐ Heart Disease/Murmur	☐ Bleeding/Transfusions	☐ Asthma	☐ Blood Dyscrasias
☐ Liver/GI Diseases	☐ Anemia	☐ Diabetes	☐ HIV/Aids
☐ Kidney Disease	☐ Rheumatic Fever	☐ Hepatitis	☐ Mental Delays
☐ Speech/Hearing Problems	☐ Seizures	☐ Cleft Lip/Palate	☐ Physical Delays
☐ Cerebral Palsy	☐ Congenital Birth Defects	☐ Personality/Social	☐ Other Problems _____
☐ Cancer/Tumors	☐ Recurrent Headaches	☐ Frequent Infections	_____

Please explain any items checked above: _____

Please List any Medications your Child takes: _____

_____

Please list all previous Hospitalizations/Surgeries/Illnesses: _____

Child's Primary Doctor: _____ Phone Number: _____

Is your child allergic to Latex or any Medications? YES ☐ NO ☐ If so, please List: _____

Assignment and Release

I hereby authorize payment directly to Dr. _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf of my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____ / _____ / _____