Welcome!

Frederick KiDDS
PEDIATRIC DENTISTRY

For your convenience, please print, complete, & bring this form with you on your first visit to our office. Thank you!

Today's Date: _____
Whom may we thank for referring you, or how did you hear about our office? _____
_____

Please Tell Us About Your Child
Child's Name: _____
Gender: Male Female
Nickname: _____
Siblings That We Treat: _____
_____
Child's Birthdate: _____ Child's Age: _____
Child's Home Address: _____
_____
_____
Child's Home Phone Number: _____
Child's Social Security Number: _____

Who is accompanying the child today?
Name: _____
Relationship: _____
Do you have legal custody of this child? Yes No

Mother's Information
Name: _____
Date of Birth: _____
Social Security Number: _____
Address: _____
_____
_____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____
Email: _____

Father's Information
Name: _____
Date of Birth: _____
Social Security Number: _____
Address: _____
_____
_____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____
Email: _____

Person Responsible For the Account
Name: _____
Relationship: _____
Address: _____
_____
_____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____

Dental Insurance
Insurance Co. Name: _____
Insurance Co. Address: _____
_____
_____
Insurance Co. Phone: _____
Name of Policyholder: _____
Relationship to Patient: _____
Policyholder's Date of Birth: _____
Plan Number: _____
Group Number: _____

Dental History
Is your child currently in pain? Yes No
What brings you to see us today? _____
_____
Is this your child's first visit to the dentist? Yes No
If not, how long since your last visit to the dentist? _____
_____
Were x-rays taken at previous dental visits? Yes No
Have there been any injuries to the teeth, face, or mouth? Yes No
If yes, please explain. _____
_____
How often does the child brush his/her teeth? _____
_____
How often does the child floss his/her teeth? _____
_____
Is the child's water fluoridated? Yes No
Is the child taking fluoride supplements? Yes No
Has the child ever had any pain/tenderness in his/her jaw/joint? (TMJ/TMD)? Yes No
Has the child ever had an unpleasant experience at the dentist? Yes No
If yes, please explain. _____
_____
_____
_____

Dental History (Con't)

Has your child ever received local anesthesia (numbing) for dental treatment? Yes No

For dental care, has your child ever been: Given laughing gas Sedated Hospitalized

Does the child have any of the following habits?

- Chewing on objects/toys
- Clenching teeth
- Nail biting
- Pacifier past 12 months of age
- Tongue/Cheek biting
- Mouth breathing
- Nursing/Bottle
- Thumb/Finger sucking
- Lip sucking/biting
- Tongue thrust while swallowing
- Speech problems
- Grinding teeth

Medical History

Name of Pediatrician: _____

Phone Number of Pediatrician: _____

Are the child's immunizations current? Yes No Has the child ever been hospitalized? Yes No

Does the child need to premedicated before dental treatment due to a heart condition or other medical condition? Yes No

Does the child have tubes in his/her ears as a result of multiple ear infections? Yes No

Is the child allergic to any medications? Yes No If "yes," please list: _____

Please list all medications, including vitamins and herbal supplements, that the child is currently taking: _____

Is the child allergic to peanuts, tree nuts, or pine? Yes No Don't Know

Has the child ever had any of the following conditions?

- ADD
- ADHD
- Allergies
- Amoxicillin Allergy
- Anemia
- Arthritis
- Artificial Joints
- Asperger Syndrome
- Asthma
- Augmentin Allergy
- Autism
- Blood Disease
- Cancer
- Cardiac Surgery
- Ceclor Allergy
- Cephalosporin Allergy
- Cerebral Palsy
- Codeine Allergy
- Depression
- Diabetes
- Developmental Delay
- Dizziness
- Down Syndrome
- Epilepsy
- Erythromycin Allergy
- Excessive Bleeding
- Fainting
- Genetic Disorder
- Hay Fever
- Head Injuries
- Hearing Problems
- Heart Disease
- Heart Murmur-Significant
- Heart Murmur-Innocent
- Hepatitis
- High Blood Pressure
- Kidney Disease
- Latex Allergy
- Learning Disability
- Liver Disease
- Mental Disorders
- Migraines
- Nervous Disorders
- Other Drug Allergy
- Pacemaker
- Penicillin Allergy
- Pregnant
- Radiation Treatment
- Reflux
- Requires Antibiotics
- Respiratory Problems
- Rheumatic Fever
- Seizures
- Sensory Int. Disorders
- Sinus Problems
- Speech Delay
- Stomach Problems
- Stroke
- Sulfa Allergy
- Tuberculosis
- Tumors
- Ulcers
- Other Condition (see below)

Please describe any condition the child has that is not listed above, or requires additional information: _____

_____ _____

Signature of Parent or Guardian Today's Date

I understand that the information 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 child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.