



**KIDS CARE DENTAL GROUP**  
[www.kidscaredentalgroup.com](http://www.kidscaredentalgroup.com)

**Tell us about your family...**

**1. Tell Us About Your Child**

Child's Name \_\_\_\_\_ M / F Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**2. Mother's Information**

Marital Status \_\_\_\_\_

Name \_\_\_\_\_  Stepmother  Guardian Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Social Security # \_\_\_\_\_ Email Address: \_\_\_\_\_

Address \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_<sup>CITY</sup> Work # (\_\_\_\_) \_\_\_\_\_<sup>STATE</sup> Ext. \_\_\_\_\_ Cellular Phone # (\_\_\_\_) \_\_\_\_\_<sup>ZIP</sup>

**3. Father's Information**

Marital Status \_\_\_\_\_

Name \_\_\_\_\_  Stepfather  Guardian Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Social Security # \_\_\_\_\_ Email Address: \_\_\_\_\_

Address \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_<sup>CITY</sup> Work # (\_\_\_\_) \_\_\_\_\_<sup>STATE</sup> Ext. \_\_\_\_\_ Cellular Phone # (\_\_\_\_) \_\_\_\_\_<sup>ZIP</sup>

**4. Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_<sup>CITY</sup> Work # (\_\_\_\_) \_\_\_\_\_<sup>STATE</sup> Ext. \_\_\_\_\_<sup>ZIP</sup>

**5. Primary Dental Insurance**

Policy Owner's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Owner's Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_ Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local or Policy #) \_\_\_\_\_

**6. Secondary Dental Insurance**

Policy Owner's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Owner's Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_ Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local or Policy #) \_\_\_\_\_

## 7. Dental History

Is this your child's first visit to the dentist? \_\_\_\_\_  
If not, how long since the last visit to the dentist? \_\_\_\_\_  
Were x-rays taken at previous dental visits? \_\_\_\_\_  
Have there been any injuries to the teeth, face or mouth?  
\_\_\_\_\_

If yes, please explain  
\_\_\_\_\_  
\_\_\_\_\_

Reason for child's visit today?  
\_\_\_\_\_  
\_\_\_\_\_

Does the child have any other following habits? \_\_\_\_\_  
Y N Lip Sucking / Biting      Y N Nail Biting  
Y N Nursing Bottle Habits    Y N Thumb/Finger Sucking  
Has the child ever had a serious or difficult problem associated with previous dental work?      Yes    No  
If yes, please explain  
\_\_\_\_\_

Has the child ever had any pain or tenderness in his/her jaw joint? (TMJ/TMD)?      Yes    No  
Does the child brush his/her teeth daily?      Yes    No

## 8. Health History

Change in general health in the past year?	Yes	No
Presently under care of a physician for a medical disorder?	Yes	No
Taking medication regularly?	Yes	No
If yes, please list: _____		

Subject to nervous disorders/fainting/dizziness?	Yes	No
Sensitive or allergic to any drug? (e.g. penicillin)	Yes	No
Subject to blood or bleeding disorders?	Yes	No
Bruise easily?	Yes	No
History of allergic reactions or allergies?	Yes	No
Allergic to latex?	Yes	No
History of heart trouble, diabetes, asthma, epilepsy, rheumatic fever, tuberculosis?	Yes	No
Unfavorable reaction from any previous dental or medical treatment?	Yes	No
Taking fluoride vitamin supplements or drinking fluoridated water?	Yes	No

In order to more properly treat child, it is imperative that you describe any and all difficulties of medical and dental nature which your child has experienced.  
\_\_\_\_\_  
\_\_\_\_\_

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Whom may we thank for referring you to our office?  
\_\_\_\_\_

Reviewed by Doctor \_\_\_\_\_

9. I request and authorize dental treatment and procedures for my minor child including the taking of dental x-rays and use of local anesthetics and/or nitrous oxide as may be necessary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

10. I understand that Kids Care Dental Group will bill my dental insurance as a courtesy but that I am ultimately responsible for all charges should my insurance company not pay for any reason. I also understand that my portion is due at the time treatment is rendered.  
I hereby authorize payment of dental benefits to Aaron Reeves, D.M.D.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I understand that I must provide Kids Care Dental Group with at least 48 hours notice of a change/cancellation to my child's appointment to avoid a \$50. "broken appointment fee".

11. I acknowledge that I received the following documents:  
Dental Material Fact Sheet and Notice of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_