ALL KIDS DENTAL / Joe Wilson, D.D.S.

Child's Name (First and Last): _____ Nickname_____

Male / Female Age_____ Date of Birth_____

Father's Name_____ Employ er_____ Social Security #_____ DOB_____

Mother's Name_____ Employer_____ Social Security #_____ DOB _____

Address_____City/State _____Zip_____ Child lives with: Mother ___ Father___ or Both___

Primary Phone # _____ Mothers Work _____ Fathers Work _____ Other #: _____

Email Address for confirmations: _____

How did you hear about our office? _____

Date and place of last dental care:_____

Are your child's immunizations complete Yes ___ No ___ On Schedule ___ Lacking What? _____

Has your child had any of the following: (Please circle)

Asthma	Heart Problems	Mumps	Fainting Spells	Diabetes	Others_____
Blood Problems	Lung Problems	Measles	Arthritis	Epilepsy	
Blood Pressure Problems	Liver Problems	Jaundice	Tuberculosis	Hay Fever	
Rheumatic Fever	Kidney Problems	Hepatitis	Speech Problems	Special Schooling Needs	

Has your child ever been given: (please circle) Local Anesthetic General Anesthesia Antibiotics (which ones):_____

List any history of the child's adverse reactions to the above _____

List any history of family problems with the above _____

List all medications your child is presently taking _____

List all known allergies your child has _____

List any significant family medical history which could effect your child _____

1. Does your child bleed for a long time following a cut or have frequent nose bleeds? _____
2. Did you have any difficulties during pregnancy or delivery? _____
3. Has your child had any unfavorable experience in a dental or medical office? _____
4. How often does your child brush his teeth? _____ times a day. Does your child floss? _____
5. Do you consider your child to be high strung or generally nervous? _____
6. Does your child have any oral habits such as thumb sucking? _____ Grinding his/her teeth_____
7. How do you think your child will act at the Dental Office? _____
8. Is your child having any difficulty in school? _____
9. Do you as a parent visit the dentist regularly? _____
10. What is your reason for seeking dental care? _____

Any additional information which you may feel is pertinent. _____

_____

Please check appropriate box as to how you intend to pay for your treatment.

[ ] Cash [ ] Check [ ] Credit Card [ ] Dental Insurance [ ] Title XIX [ ] Marginal Dental

Insurance Co_____ Policy # _____ Group # _____ Policy Holder _____

I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law. I authorize release of any information relating to this claim. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

_____ _____

Signed (Employee/Subscriber) Date

****Since your child is a minor, It becomes necessary that a signed permission form be obtained from a parent or guardian before necessary dental treatment can be started and accomplished. *Also a legal parent/Guardian must be present in building during appointments*. This also gives the doctor the ability to administer treatment and to utilize behavior management techniques which professional judgment deems in** the patient's b**est interest during the performance of treatment**

Signature of Parent _____ Date _____