About your child

Child's full name:

_____

□ male □ female

Date of birth _____ age _____

How did you hear about us?

_____

Dental History

Is this your child's first dental visit □ yes □ no

Previous dentist:

_____

Date of last visit: _____

Any injuries to child's face or jaw?

_____

History of:

Thumb sucking □ past □ present

Pacifier use □ past □ present

Teeth grinding/clenching □ past □ present

Other habits: _____

Has your child had any unpleasant experiences or an unfavorable reaction to previous dental care? □ yes □ no

If yes, please explain:

_____

_____

Who is responsible for brushing child's teeth?

_____

Brushing: □ AM □ PM □ Both

Flossing: □ AM □ PM □ Both

Fluoride and Dietary Assessment

Does your child use fluoride toothpaste?

□ yes □ no

Does your child take prescription fluoride?

□ yes □ no

Has your child had fluoride treatments before?

□ yes □ no

Is your child a good eater? □ yes □ no

Does your child drink:

□ juice □ milk □ soda □ energy drinks

Is your child breast feeding? □ yes □ no

Is your child using a bottle or sippy cup?

□ yes □ no

Medical History

Does your child require antibiotics prior to dental treatment due to a heart defect or other medical conditions? □ yes □ no

Is your child allergic to latex, dyes or metals?

□ yes □ no

List: _____

Is your child allergic to any medications?

□ yes □ no

Please list all allergies:

_____

_____

_____

Is your child taking any medications?

□ yes □ no

List: _____

_____

Pediatrician/physician: _____
Phone: _____
Date of last check up: _____

Does your child have, ever had, or been diagnosed with any of the following? Check ***all*** that apply.

__Anemia	__Autism	__Asthma/Triggers: _____	
__Bladder conditions	__Blood disorder/sickle cell	__Blood transfusion	__Birth defects
__Bone or joint problems	__Brain injury	__Bruising easily	__Child abuse
__Cancer or malignancies	__Cerebral palsy	__Chemotherapy or radiation	__Cleft lip/palate
__Chronic ear infections	__Chronic headaches	__Congenital heart defect	__Drug addiction
__Convulsions/Seizures	__Developmentally delayed	__Diabetes	__Excessive bleeding
__Emotional disturbance	__Epilepsy	__Eye problem	__Heart surgery
__Excessive gagging	__Fainting or dizziness	__Fever blister/cold sores	__Hemophilia
__Growth problems	__Hearing/speech impediment	__Heart murmur/defect	__Hyperactivity/ADHD
__Hepatitis or liver disease	__High blood pressure	__HIV	__Nutritional deficiency
__Kidney disease	__Leukemia	__Neurological problems	__Psychiatric care
__Orthopedic problems	__Pain in jaw joints	__Premature birth	__Sleep apnea/snoring
__Respiratory disease	__Rheumatic fever	__Sensory integration disorder	__Shunts

Is your child currently under the care of a physician or specialist for any reason? □ yes □ no
Reason for care: _____

If needed, please describe any checked items further:
_____
_____
_____
_____

Do you wish to speak with the doctor privately about special concerns? □ yes □ no

Does your child have any other condition not listed on this page? □ yes □ no
List: _____

Parent/Guardian Information

Father:

_____

Mother:

_____

Step parent:

_____

Legal guardian:

_____

□ Married □ Single □ Divorced □ Widowed

Home address of responsible party:

_____

_____

City and **zip code**:

_____

Work phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Insurance Information

Insurance company and employer:

_____

Subscriber/Policy holder's name:

_____

Relationship to child:

_____

Subscriber/Policy holder's DOB:

_____

Subscriber/Policy holder's social security #:
(If your child has Colorado health OP, list their social security number).

_____

ID #: _____

Group #: _____

Does this child have Medicaid? □ yes □ no

Medicaid #: _____

Secondary Insurance Information

Insurance company and employer:

_____

Subscriber/Policy holder's name:

_____

Relationship to child:

_____

Subscriber/Policy holder's DOB:

_____

Subscriber/ Policy holder's social security #:
(If your child has Colorado health OP, list their social security number).

_____

ID #: _____

Group #: _____

Authorization

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that payment is due at the time services are rendered. I hereby authorize payment directly to Littleton Kids Dental and Orthodontics from any insurance company listed above. I agree to the payment of any co-pays, deductibles, and uncovered services or amounts. I authorize the release of any dental information necessary to process insurance claims or for determination of benefits. If my account requires servicing for collection, I understand that I will be liable for all fees incurred.

Signature:_____

Today's date: _____