



Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_ Nickname \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Gender  M  F

Alternate Contact Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**INSURANCE INFORMATION**

PLEASE PRESENT THE FRONT DESK WITH A COPY OF YOUR CURRENT ID CARD

Name of Insured \_\_\_\_\_ Employer: \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_

Insurance Carrier \_\_\_\_\_ Group # \_\_\_\_\_

Who has Legal custody of this patient? \_\_\_\_\_

What is the reason for your child's visit today? \_\_\_\_\_

**HEALTH HISTORY**

Name of child's Physician \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

Y  N Is your child in good health?

Y  N Has your child ever had a health problem?

List \_\_\_\_\_

Y  N Has your child ever been hospitalized or had any surgical procedure performed?

Please give reason and dates? \_\_\_\_\_

Y  N Is your child allergic to any medications or foods (latex, penicillin, bananas)?

Please List \_\_\_\_\_

Y  N Is your child currently taking any medications?

Please list medication & reason \_\_\_\_\_

Y  N Were there any problems at birth? Weight at Birth? \_\_\_\_ lb \_\_\_\_ oz

List \_\_\_\_\_

Y  N Is your child adopted or a foster child? If yes, please specify: \_\_\_\_\_

Do you consider your child's development & learning to be (please circle): advanced normal slow

Please circle if any of the following apply to your child:

- |                     |                             |                    |                     |                  |
|---------------------|-----------------------------|--------------------|---------------------|------------------|
| Heart Disease       | Bleeding/Blood Transfusions | Asthma             | LATEX allergy       | Autism PPD       |
| Mental Delays       | Down Syndrome               | Speech/hearing     | Seizure/Epilepsy    | Cleft lip/palate |
| Eyes/vision         | Cerebral palsy              | Congenital defect  | Personality/ Social | Heart Murmur     |
| Recurrent Headaches | Cancer/Tumors               | Frequent Infection | Tubes/Ear Infection | Genetic disorder |
| Physical Delays     | Hepatitis                   | Other Conditions   |                     |                  |

PLEASE ELABORATE ON ANY ITEMS CIRCLED:

Names & Ages of Siblings \_\_\_\_\_

Child's Hobbies, Pets & Interests \_\_\_\_\_

Favorite Snacks Foods \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

### DENTAL HISTORY

Y  N Has your child ever been to the dentist? Name of previous dentist and date: \_\_\_\_\_

Y  N Has your child experienced any unfavorable experiences or reactions to previous dental care?

Please explain: \_\_\_\_\_

Y  N Does your child suck a finger, thumb, or pacifier? \_\_\_\_\_

Y  N Is your child having any dental pain? Location of pain: \_\_\_\_\_

Y  N Are you & your child happy with your child's smile?

Describe your concerns: \_\_\_\_\_

Y  N Is your child active in sports? List: \_\_\_\_\_

Y  N Does your child wear an athletic mouth guard while playing sports?

Was your child:  Breast fed  Bottle fed At what age was it discontinued? \_\_\_\_\_

Does your child use a "sippy cup"?  Y  N If yes, what is placed in the cup: \_\_\_\_\_

Who brushes your child's teeth? \_\_\_\_\_ Flossing: \_\_\_\_\_

Please circle if your child is having problems with any of the following:

Cavities

Toothache/Pain

Sensitive Teeth

Trauma

Gum Infections

Color of teeth

Orthodontics/Crowding

Jaw Sounds

Other

COMMENTS: \_\_\_\_\_

### FLOURIDE HISTORY

Y  N Is your home water supply fluoridated?

Y  N Does your child use fluoride toothpaste?

Y  N Do you give your child any other forms of fluoride?

### CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Banks & her staff to examine, clean, and provide dental treatment on my child's teeth. I further request & authorize the taking of dental x-rays as may be considered necessary by Dr. Banks to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic & educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Banks & her staff will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation & demonstration of procedures & instruments, & using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment. I understand that the estimated portion of the treatment amount is due at the time of service and that any amount left unpaid by insurance is my responsibility to pay within 60 days. I hereby authorize payment of dental insurance benefits, if any to be made directly to Dr. Jessie M. Banks

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

I give my permission for the following adults to accompany my child to future dental appointments & make treatment decisions concerning my child when I am not present.

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

At each appointment, our office would like to photograph your child to post on our "Kitsap Kids" wall: I give permission to post my child's picture which is identified by their first name only?  Y  N

I do not wish to receive appointment reminders via email. Please remove me from your contact list.