Lubbock KIDS Dental

1504 Buddy Holly Ave, Lubbock, TX 79401 (806)749-KIDS

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Patient Information

Child's Name_____ M [ ] F [ ]

Age_____ Date of Birth_____ School/Daycare_____

Home Address_____City_____State_____ZIP_____

Home Phone_____Mobile Phone_____Message/Pager_____

Work Phone_____e-mail_____

Emergency Contact: _____Phone_____

Insurance Information

Dental Insurance Plan YES [ ] NO [ ] Insurance Company Name _____

Please provide your insurance card for the receptionist to make a copy.

CIDC/Medicaid YES [ ] NO [ ]

Please provide your card for the receptionist and bring a current card each time you come for an appointment.

Medical and Dental History

Child's Physician/Pediatrician_____Phone_____

Is your child presently under medical care? YES [ ] NO [ ] If yes, explain _____

Is your child currently taking medications? YES [ ] NO [ ] If yes list_____

Any known allergies or reactions (medications, drugs, food, etc.)? YES [ ] NO [ ]

If yes, explain_____

Has your child ever had any of the following medical problems?

Heart Disease	YES	NO	**Kidney Problems**	YES	NO	**Tuberculosis**	YES	NO
Heart Murmur	YES	NO	**HIV/AIDS**	YES	NO	**Bone Problems**	YES	NO
Congenital Heart Defect	YES	NO	**Epilepsy/Seizures/Fainting**	YES	NO	**Asthma**	YES	NO
Rheumatic Fever	YES	NO	**Diabetes**	YES	NO	**Hearing Loss**	YES	NO
Bleeding Disorder	YES	NO	**Hepatitis**	YES	NO	**Vision Loss**	YES	NO
Liver Problems	YES	NO	**Cancer/Leukemia**	YES	NO	**Surgery**	YES	NO
Down Syndrome	YES	NO	**Cerebral Palsy**	YES	NO	**Birth Defects**	YES	NO

Explain any other relevant health problems:_____

First dental visit? YES [ ] NO [ ] If no, who/where was the previous dentist? _____

Previous dental treatment (fillings, crowns, extractions?) YES [ ] NO [ ]

Previous sedation or general anesthesia for dental treatment? YES [ ] NO [ ]

Were you satisfied with the previous dental care? YES [ ] NO [ ] don't know [ ]

Has your child experienced any unfavorable reaction from previous dental care? YES [ ] NO [ ]

If yes, explain_____

Has your child ever fallen or otherwise injured his/her teeth? YES [ ] NO [ ] When? _____ How?_____

Any bad mouth habits (finger, thumb, pacifier,etc.) YES [ ] NO [ ] Explain_____

Does your child have siblings? YES [ ] NO [ ] Also patients with us? YES [ ] NO [ ]

If yes, please list_____

Parent/Guardian/Parenting Adult Information

Name_____ SSN_____

Employment_____Phone_____

Marital Status S [ ] M [ ] D [ ] Relationship to child: Father [ ] Mother [ ] Other [ ]_____

Name_____SSN_____

Employment_____Phone_____

Marital Status S [ ] M [ ] D [ ] Relationship to child: Father [ ] Mother [ ] Other [ ]_____

Person responsible for account:_____

Billing address_____

Payment is due the day services are rendered

I hereby authorize Lubbock KIDS Dental to furnish information to my insurance carrier concerning dental treatment. I hereby assign all payment for dental services rendered to Lubbock KIDS Dental. I understand I am responsible for amounts not covered.

Signature _____Date_____