# CLAYTON KIDS DENTISTRY

## Shraddha Patel Kolappa, DDS

### Patient Registration & Health History

## Whom May We Thank For Referring You?

General Dentist ❑ Friend/One of Our Patients ❑ _____ Internet ❑ Other ❑ _____

## Patient Information

Patient Name (Last, First, MI): _____ Today's Date: _____

Birthdate: _____ Age: _____ Male ____ Female ____ Nickname: _____

Child's Home Phone: _____ Child's Home Address: _____

School: _____ Grade: _____ Email Address We May Use: _____

Tell Us About Your Child: _____

## Family Information

Name of Person Who is Accompanying Your Child Today: _____ Relationship: _____

Do you have legal custody of this child? Yes ___ No ___ Is your child adopted? Yes ___ No ___

Parent's Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

List brothers / sisters with ages: _____

## Mother's Information

Name: _____ Birthdate: _____ Check Appropriate: Step-Mother ___ Guardian ___

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ SSN: _____

## Father's Information

Name: _____ Birthdate: _____ Check Appropriate: Step-Father ___ Guardian ___

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ SSN: _____

## Responsible Party & Primary Dental Insurance

Person Responsible for Account: _____ Insurance Co. Name: _____

Insurance Co. Address: _____ Insurance Co Phone: _____

Policy Owner's Name: _____ Policy Owners Birthdate: _____

Relationship to Patient: _____ Group Number: _____ Policy Holder ID: _____

Policy Owner's Employer: _____ Employer's Address: _____

## Secondary Dental Insurance

Orthodontic Coverage: Yes ___ No ___ Insurance Co. Name: _____

Insurance Co. Address: _____ Insurance Co Phone: _____

Policy Owner's Name: _____ Policy Owners Birthdate: _____

Relationship to Patient: _____ Group Number: _____ Policy Holder ID: _____

Policy Owner's Employer: _____ Employer's Address: _____

## Health History

Is this your child's first dental visit? Yes ___ No ___ Last Visit Date: _____ Your General Dentist: _____

Has your child had an unfavorable experience in a dental office? Yes ___ No ___

What are the main concerns for this dental visit? _____

Have there been any injuries to the face, mouth teeth or chin? _____

Have you been informed that your child has any missing or extra permanent teeth? .....Yes ___ No ___

Has your child had any pain / tenderness in his / her jaw joint (TMJ / TMD)? .....Yes ___ No ___

Does your child brush his / her teeth daily? .....Yes ___ No ___ Floss his / her teeth daily? .....Yes ___ No ___

Is your home water supply city water or well water? Please check one: Well Water ____ City Water ____

If your child has ever experienced any of the following place a check mark in the box next to the item: ☑

- ❑ Clenching / Grinding Teeth
- ❑ Lip Sucking/Biting
- ❑ Mouth Breather
- ❑ Nail Biting
- ❑ Nursing Bottle Habits
- ❑ Speech Problems
- ❑ Thumb/Finger/Pacifier Sucking
- ❑ Tongue Thrust

COMMENTS: _____

Please describe your child's current physical health (circle one): Good Fair Poor

Is your child currently under the care of a physician? .....Yes ___ No ___

Child's Physician: _____ Phone Number: _____ Date of last visit: _____

Please list all drugs / things your child is allergic to or write "None": _____

Is your child allergic to: Latex.....Yes ___ No ___ Metals/Nickel..... Yes ___ No ___ Plastics.....Yes ___ No ___

Has your child had an unfavorable reaction to Penicillin, Aspirin, Novocaine or any other medication?

If "Yes", What Type of Reaction?_____

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

*Circle Y for Yes and N for No*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding | Y | N | Asthma - Chronic or Acute | Y | N | Heart Murmur |
| Y | N | ADD / ADHD | Y | N | Cancer | Y | N | Hemophilia |
| Y | N | Allergies to any Drugs | Y | N | Congenital Heart Defect | Y | N | Hepatitis |
| Y | N | Allergic to Latex / Metals | Y | N | Convulsions/Epilepsy | Y | N | HIV+ / AIDS |
| Y | N | Allergic to Plastics | Y | N | Diabetes | Y | N | Kidney/Liver Problems |
| Y | N | Any Hospital Stays | Y | N | Fluoride Treatments | Y | N | Lupus |
| Y | N | Any Operations | Y | N | Handicaps / Disabilities | Y | N | Rheumatic/Scarlet Fever |
| Y | N | Artificial bones/Joints/valves | Y | N | Hearing Impairment | Y | N | Tuberculosis (TB) |
| Y | N | Autism | Y | N | Downs Syndrome | Y | N | Family History of TB |
| Y | N | Sensory Disorder (To What?)_____ | | | | Y | N | Developmentally Delayed |

Please discuss any medical problems that your child has had: _____

Medications:_____

## Financial Responsibility & Authorization Signature

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

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian _____ Date: _____

The Parent or Guardian who accompanies the child is responsible for payment. Payment is due at the time service is rendered. As a courtesy we will file your insurance for you; any co-payment or required deductible is due at the time service is rendered. We accept assignment of insurance benefits and all payments made by your insurance carrier will be paid directly to our practice. In the event insurance does not pay for the services rendered, the responsible party will be billed for services in their entirety.

Signature of parent or guardian _____ Date: _____