Dentistry for Kids
Dr Kris Hendricks
Dr Jason Gonzalez
Dr Kasey Hall
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Patient Name_____Preferred Name_____
Date of Birth:___/___/___ Female___Male___ Current Age_____
Child's Social Security Number_____
Name of Parent/Guardian filling out form_____

Mother's Name_____Marital Status_____
Mother's Social Security Number_____Mother's Birthdate_____
Mother's Employer_____Mother's Work Phone_____
Mother's Mailing Address_____
City_____State_____Zip_____
Home Number:_____Cell Phone Number:_____
Preferred Contact #(check one): Home___Cell___Email address:_____
Do you allow us to contact you via email or text to communicate patient information?Y__N__

Father's Name_____Marital Status_____
Father's Social Security Numberr_____Father's Birthdate_____
Father's Employer_____Father's Work Phone_____
Father's Mailing Address_____
City_____State_____Zip_____
Home Number:_____Cell Phone Number:_____
Preferred Contact #(check one): Home___Cell___Email address:_____
Do you allow us to contact you via email or text to communicate patient information?Y__N__

DENTAL INSURANCE INFORMATION

If you receive financial assistance for your child's dental care, please check the option that applies: Medicaid_____CMS_____Project ANN_____Other_____

Primary Policy Information
Name of Policy Holder: _____
Insurance Name: _____Ins phone #_____
Member ID: _____ Group #_____
Policy Holder's Birthdate _____/_____/_____
Policy Holder's Social Security # _____/ _____/_____(required to file claims)
Employer:_____

Secondary Policy information
Name of Policy Holder: _____
Insurance Name: _____Ins phone #_____
Member ID: _____ Group#_____
Policy Holder's Birthdate _____/_____/_____
Policy Holder's Social Security # _____/ _____/_____ (required to file claims)
Employer:_____

Dentistry for Kids Kris W. Hendricks, DDS

Patient Name_____ Account #_____

Is this your child's first visit to a dentist? __Yes __No

Was previous experience __good __bad __other Explain_____

How did you find us? Internet___ Phone Book (which one?)_____ Ad___Friend___Other_____

Please tell us the main reason for today's visit_____

Has your child been experiencing dental pain? __yes __no

Has your child been awake at night from dental pain? __yes __no

Do you have any concerns about your child's dental health?_____

Has your child ever been hospitalized? __yes __no If yes please give date & reasons_____

Is your child allergic to any medications? __yes __no Please identify_____

Is your child currently taking any medications? __yes __no Please identify_____

Reason for the medication_____ Pediatrician name & phone_____

Has your child had: DPT immunization __yes __no Polio vaccine __yes __no Measles Mumps & German measles __yes __no

Is there anything you can tell us about your child that could assist us in taking the best possible care of them?

_____

Does your CHILD now have or have they ever had in the past: (please circle y or n)

Speech problems	Y N	Anemia/Sickle Cell Disease	Y N	Cerebral Palsy	Y N
Hearing problems	Y N	Bruises Easily	Y N	Seizures	Y N
Asthma	Y N	Blood Transfusion	Y N	Kidney/Bladder problems	Y N
Skin problems	Y N	Hepatitis/Jaundice	Y N	Diabetes	Y N
Allergies (other)	Y N	Cystic Fibrosis	Y N	Pregnancy (patient)	Y N

Please Identify Allergies_____

Has patient had heart disease or a heart murmur Y N Please describe_____

Is pre-medication required for dental treatment? Y N Drug preferred_____Child's Weight_____

Please circle all illnesses your child has previously had:

Chickenpox Earaches Measles German Measles Mumps Mononucleosis HIV/AIDS Scarlet Fever Tuberculosis Venereal Disease Tonsillitis

Learning/Behavior Disorders Y N Please describe_____

Has your child had any prior surgeries? Y N Is your child currently scheduled for surgery? Y N Date?_____

Please describe_____

Is there anything else we should know about your child?

Is your child a picky eater? Y N

Parent/Guardian Signature_____Date_____