



9456 Renner Blvd,  
Lenexa, KS 66219  
913-379-6527

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## ABOUT YOUR CHILD

Name: \_\_\_\_\_  
Last First M

Nickname: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male Female

Social Security # : \_\_\_\_\_

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

Home Address: \_\_\_\_\_  
Apt #

\_\_\_\_\_  
City State Zip Code

Home Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_

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## ABOUT YOU

Your Name: \_\_\_\_\_  
Last First M

Relationship to child: \_\_\_\_\_

Person Responsible for child: \_\_\_\_\_

Your home phone and address if different from  
child's:

Home Address: \_\_\_\_\_  
Apt #

\_\_\_\_\_  
City State Zip Code

Home Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

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## INSURANCE

### DENTAL INSURANCE COMPANY #1

Do you have dental insurance?  
Yes No

Group #: \_\_\_\_\_

This Dental Insurance is provided through:

Their name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Their Social Security #: \_\_\_\_\_

Their Birth Date: \_\_\_\_\_

Their Employer: \_\_\_\_\_  
\_\_\_\_\_

### DENTAL INSURANCE COMPANY #2

Do you have Secondary dental insurance?  
Yes No

Group #: \_\_\_\_\_

This Dental Insurance is provided through:

Their name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Their Social Security #: \_\_\_\_\_

Their Birth Date: \_\_\_\_\_

Their Employer: \_\_\_\_\_  
\_\_\_\_\_

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### MEDICAL/DENTAL HISTORY

Has your child been to the dentist before?

Yes No

If yes, the approximate date of last visit:

\_\_\_\_\_

Are there any dental problems that you are aware of at present time? Yes No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Does your child brush his/her teeth daily?

Yes No

Is your child currently under the care of a physician?

Yes No

Child's Physician: \_\_\_\_\_

Their Phone #: \_\_\_\_\_

Is your child allergic to any drugs?

Yes No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Does your child need to be pre-medicated for artificial joints, heart murmur or mitral valve prolapsed before dental treatment?

Yes No

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### MEDICAL/DENTAL HISTORY

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

Please Circle

- |   |   |                               |
|---|---|-------------------------------|
| Y | N | Heart Murmur                  |
| Y | N | Heat problems of any kind     |
| Y | N | Convulsions/Epilepsy          |
| Y | N | Cancer                        |
| Y | N | Diabetes                      |
| Y | N | Rheumatic Fever               |
| Y | N | HIV + / AIDS                  |
| Y | N | Hemophilia                    |
| Y | N | Bleeding problems of any kind |
| Y | N | Hearing Impairment            |
| Y | N | Hyperactive                   |
| Y | N | Any Operations                |
| Y | N | Any Stays in Hospital         |
| Y | N | Other _____                   |

I understand tha the information, that I have givien is corect to the best of my knowledge, that I will be held in the most strict of confidence and it is my responsibility to inform this office of any changes in my child's medical status, I also authrozie the dental staff to perform the necessary dental servies my child may need.

Signature of parent of guardian \_\_\_\_\_ Date: \_\_\_\_\_