

PEDIATRIC DENTISTRY

RICHARD W. KENNEDY, D.M.D.

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CHILD'S NAME _____ BIRTHDATE _____ SEX ____ AGE ____
 CHILD'S SOCIAL SECURITY # _____

FATHER'S NAME _____ BIRTHDATE _____ S.S.# _____
 FATHER'S ADDRESS _____ CITY _____ STATE ____ ZIP ____
 FATHER'S EMPLOYER _____ HOME PHONE _____ WORK PHONE _____
 FATHER'S E-MAIL _____ MOBILE PHONE _____

MOTHER'S NAME _____ BIRTHDATE _____ S.S.# _____
 MOTHER'S ADDRESS _____ CITY _____ STATE ____ ZIP ____
 MOTHER'S EMPLOYER _____ HOME PHONE _____ WORK PHONE _____
 MOTHER'S E-MAIL _____ MOBILE PHONE _____

CHILD'S MEDICAL DOCTOR _____ LAST VISIT _____ REASON _____

NAME OF PRIMARY DENTAL INSURANCE _____ NAME OF SECONDARY DENTAL INSURANCE _____
 NAME OF INSURED _____ NAME OF INSURED _____
 GROUP # _____ GROUP # _____

DO YOU HAVE A WELFARE CARD? _____ IF YES PLEASE SHOW THE RECEPTIONIST _____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

HOW DID YOU LEARN ABOUT THIS OFFICE? _____

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PLEASE READ CAREFULLY

BECAUSE YOUR CHILD IS A MINOR, IT BECOMES NECESSARY THAT A SIGNED PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY/AND ALL NECESSARY DENTAL SERVICES CAN BE STARTED AND ACCOMPLISHED BY DR. KENNEDY.

AUTHORIZATION IS HEREBY GRANTED AS SUCH. FURTHERMORE, I WILL BE RESPONSIBLE FOR ANY FEE CHARGED FOR THIS DENTAL AGREEMENT. I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO DENTAL CLAIMS TO MY INSURANCE COMPANY.

NOTE: OUR OFFICE POLICY IS THAT ALL ACCOUNTS WILL BE BILLED TO THE PARENT AUTHORIZING DENTAL TREATMENT

Signature _____ Relationship _____ Date _____



Any mouth habits (thumb-sucking, etc.)?
 Any injuries to the mouth, teeth, or head?
 Any unhappy dental visits?
 Current dental problem?
 Last visit to a Dentist?

DENTAL INFORMATION

Does your child have any special problems not listed above?
 Has your child ever received any transfusions or blood, blood products or blood elements?
 Has your child had any operations? If so, what type?
 Has your child ever been hospitalized? If so, for what reason?
 Has your child ever taken penicillin or amoxicillin? Any allergic reactions?
 Is your child presently taking any medications? If so, what and prescribed by whom?

29. Vomiting	<input type="radio"/>	<input type="radio"/>
28. Venereal disease	<input type="radio"/>	<input type="radio"/>
27. Tuberculosis	<input type="radio"/>	<input type="radio"/>
26. Rheumatic fever	<input type="radio"/>	<input type="radio"/>
25. Radiation therapy	<input type="radio"/>	<input type="radio"/>
24. Pregnancy	<input type="radio"/>	<input type="radio"/>
23. Mental Retardation	<input type="radio"/>	<input type="radio"/>
22. Malignancy or leukemia	<input type="radio"/>	<input type="radio"/>
21. Liver disorders	<input type="radio"/>	<input type="radio"/>
20. Learning disabilities	<input type="radio"/>	<input type="radio"/>
19. Kidney disorders	<input type="radio"/>	<input type="radio"/>
18. Hyperactivity	<input type="radio"/>	<input type="radio"/>
17. Hepatitis	<input type="radio"/>	<input type="radio"/>
16. Heart problems	<input type="radio"/>	<input type="radio"/>
15. Heart murmur	<input type="radio"/>	<input type="radio"/>
14. Hearing problems	<input type="radio"/>	<input type="radio"/>
13. Fainting	<input type="radio"/>	<input type="radio"/>
12. Epilepsy	<input type="radio"/>	<input type="radio"/>
11. Emotional problems	<input type="radio"/>	<input type="radio"/>
10. Diabetes	<input type="radio"/>	<input type="radio"/>
9. Convulsions or seizures	<input type="radio"/>	<input type="radio"/>
8. Cerebral palsy	<input type="radio"/>	<input type="radio"/>
7. Bladder	<input type="radio"/>	<input type="radio"/>
6. Asthma	<input type="radio"/>	<input type="radio"/>
5. Arthritis	<input type="radio"/>	<input type="radio"/>
4. Anemia	<input type="radio"/>	<input type="radio"/>
d) Other	<input type="radio"/>	<input type="radio"/>
c) Latex	<input type="radio"/>	<input type="radio"/>
b) To any medications (drugs)	<input type="radio"/>	<input type="radio"/>
a) To Local anesthetic	<input type="radio"/>	<input type="radio"/>
3. Allergies	<input type="radio"/>	<input type="radio"/>
2. AIDS or AIDS related complex	<input type="radio"/>	<input type="radio"/>
1. Abnormal bleeding problems	<input type="radio"/>	<input type="radio"/>

NO YES If "YES", please give a brief explanation

Please read and answer EACH question. Please check (✓) if your child has had any problem or history of the following. If you need assistance, we will be glad to help you.

MEDICAL INFORMATION