T 610.265.4142 F 610.265.0926 kingofprussiadental.com

King of Prussia Dental
DENTAL ASSOCIATES GROUP MEMBER

YOUR CHILD'S PATIENT HISTORY

Welcome to King of Prussia Dental Associates, and thank you for entrusting your child to our care. We are committed to providing the best possible dental assessment and treatment, and the first step is to gather detailed information about your child's dental and medical history and current needs. Our office policies are in strict compliance with HIPAA (Health Insurance Portability and Accountability Act), which protects patient privacy.

TODAY'S DATE _____

PLEASE TELL US ABOUT YOUR CHILD:

Name _____ (First / Last / M.I) Nickname _____

Birth Date _____ Age _____ Male ☐ Female ☐ SS# _____

Street Address _____ City _____ State _____ Zip _____

Telephone _____ Email _____ School _____ Grade _____

Previous / Present Dentist _____ Date of Last Visit _____

WHO HAS BROUGHT THIS CHILD TO SEE US TODAY?

_____

Name Relationship Do you have legal custody?: Yes ☐ No ☐

PLEASE TELL US ABOUT YOUR CHILD'S FAMILY BACKGROUND:

☐ Mother ☐ Step-Mother ☐ Guardian (Please check one)

Name _____ Birth Date _____

W.k.# _____ Ext _____ Hm.# _____

Employer _____

SS# _____ Cell # _____

☐ Father ☐ Step-Father ☐ Guardian (Please check one)

Name _____ Birth Date _____

W.k.# _____ Ext _____ Hm.# _____

Employer _____

SS# _____ Cell # _____

Parent's marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partners ☐ Separated

Is this child adopted? Yes ☐ No ☐ Is this child living in a foster home? Yes ☐ No ☐

Any siblings we have seen in our practice: _____

Neighbor or relative not living with your family: Name _____ Phone _____

Address _____

Whom may we thank for referring you to our practice? _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?

Name _____ Relation _____ Wk.# _____ Ext _____ Hm.# _____

Billing Address _____

Employer _____ DL# _____ SS# _____

WHO WILL MAKE APPOINTMENTS?

Name _____ Wk.# _____ Ext _____ Hm.# _____

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____

Ins. Co. Address _____

Ins. Co. Phone # _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ ID# _____

Policy Owner's Employer _____

Employer's Address _____

Orthodontic Coverage? Yes ☐ No ☐

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____

Ins. Co. Address _____

Ins. Co. Phone # _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ ID# _____

Policy Owner's Employer _____

Employer's Address _____

Orthodontic Coverage? Yes ☐ No ☐

CONTINUED ON REVERSE >>>

T 610.265.4142 F 610.265.0926 kingofprussiadental.com

King of Prussia Dental
DENTAL ASSOCIATES GROUP MEMBER

YOUR CHILD'S DENTAL HEALTH

Why have you brought this child to see us today?

_____

_____

Has this child ever experienced any serious problem connected with previous dental treatment? Yes ☐ No ☐

Has this child ever experienced pain or tenderness in his or her jaw joint (TMJ / TMD)? Yes ☐ No ☐

Is the water this child drinks fluoridated? Yes ☐ No ☐

Is this child taking fluoride supplements? Yes ☐ No ☐

Does this child brush his or her teeth daily? Yes ☐ No ☐

Does this child floss his or her teeth daily? Yes ☐ No ☐

YOUR CHILD'S GENERAL HEALTH

Which best describes this child's current physical health:

☐ Good ☐ Fair ☐ Poor

Are this child's immunizations up to date? Yes ☐ No ☐

Has this child ever taken Fosamax, Actonel, Boniva, or any other bisphosphonate (osteoporosis treatment)? Yes ☐ No ☐

Is this child currently under the care of a physician? Yes ☐ No ☐

Physician's Name _____

Phone # _____ Last Visit _____

Does or did this child ever experience any of the following:

Lip sucking or biting Yes ☐ No ☐
Nail biting Yes ☐ No ☐
Thumb or finger sucking Yes ☐ No ☐
Nursing bottle related habits Yes ☐ No ☐
Was the child breast-fed? Yes ☐ No ☐

Does this child have any of the following allergies:

Latex Y ☐ N ☐ **Metals / Nickel** Y ☐ N ☐ **Plastic** Y ☐ N ☐

Please list any drugs or other substances to which this child is allergic:

_____

_____

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

Y ☐ N ☐ **Abnormal Bleeding**	Y ☐ N ☐ **Heart Murmur**
Y ☐ N ☐ **ADD / ADHD**	Y ☐ N ☐ **Hemophilia**
Y ☐ N ☐ **Anemia**	Y ☐ N ☐ **Hepatitis**
Y ☐ N ☐ **Artificial Bones/Joints/Valves**	Y ☐ N ☐ **Hives**
Y ☐ N ☐ **Asthma**	Y ☐ N ☐ **HIV+ / AIDS**
Y ☐ N ☐ **Cancer**	Y ☐ N ☐ **Hospital Stays**
Y ☐ N ☐ **Chicken Pox**	Y ☐ N ☐ **Kidney / Liver Problems**
Y ☐ N ☐ **Congenital Heart Defect**	Y ☐ N ☐ **Measles**
Y ☐ N ☐ **Convulsions**	Y ☐ N ☐ **Mononucleosis**
Y ☐ N ☐ **Diabetes**	Y ☐ N ☐ **Rheumatic / Scarlet Fever**
Y ☐ N ☐ **Epilepsy**	Y ☐ N ☐ **Sickle Cell Disease / Traits**
Y ☐ N ☐ **Exposed to HIV, but Negative**	Y ☐ N ☐ **Skin Rash**
Y ☐ N ☐ **Handicaps / Disabilities**	Y ☐ N ☐ **Surgical Operation**
Y ☐ N ☐ **Hearing Impairment**	Y ☐ N ☐ **Tuberculosis (TB)**

Please describe any serious medical problem this child has experienced:

_____

_____

Please list any medications that this child is currently taking:

_____

_____

Are there any issues that you would like to discuss with the doctor in private?

Yes ☐ No ☐

The Parent or Guardian who accompanies this child is responsible for payment at the time of service, unless alternative arrangements have been made and approved in advance.

Please read and sign the following statements, supplying the information requested:

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

I will use the following method of payment: _____

_____

Signature of Parent or Guardian Date

I certify that my child's treatment is covered by the _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits that are otherwise payable to me. I understand that I am responsible for payment for services rendered, and also for any co-payment and/or deductible that my insurance does not cover. I hereby authorize this office to release all information necessary to secure the payment of these benefits. I authorize the use of this signature on all of my insurance submissions processed by this office, both manual and electronic.

_____

Signature of Parent or Guardian Date

OFFICE USE ONLY

I verbally reviewed the medical and dental information above with the Parent/ Guardian or Patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

Medical History Updates

Date: _____ Signature: _____

Comments: _____

_____