Date ___________________

PATIENT INFORMATION SHEET

Patient Information

Patient's Last, First Name _________________________ Nickname ____________ B.D. __________ Age _____

Male or Female Was patient adopted? Y or N

Patient's Address ____________________________________ City _________________ Zip _____________

List Family Siblings: ____

Parent (Dad) Last, First name ______________________________ 1st # ____________ (**Cell or Land**); 2nd # ____________

Address (if different than above)____

Parent (Mom) Last, First name _____________________________ 1st # ____________ (**Cell or Land**); 2nd # ___________

Address (if different than above)____

Parent's Information (Whether you have insurance or not)

Parent (Dad)

B.D. ____________ S.S. # __________________ Group # ______________ Sub/ID# ____________________

Dental Ins/Address ____Phone _______________

Employer _________________ Occupation ____________ Work # ________________ Primary or Secondary

Parent (Mom)

B.D. ___________ S.S. # __________________ Group # ______________ Sub/ID# ____________________

Dental Ins/Address ____Phone _______________

Employer _________________ Occupation ____________ Work # _______________ Primary or Secondary

Person Financially responsible for account? _______________________________

*** Mastercard/Visa, Cash, Check and Insurance are accepted for payment on your account ***

Confirming Appointments: Our goal is to verbally confirm each appointment in order to effectively accommodate our patients and appointments needed. If you need to cancel, please contact our office at least 24 hours prior to your appointment. We also offer Email and Text confirmations. Email _________________________Text _________ (to "opt in", please text kidsdentist to 622622)

Would you like to receive statements on your account via email? Yes or No

Dental Information

What is the purpose of this dental visit? ____

X-rays from another office? They can be emailed to us at office@thefunkidsdentist.com. Previous Dentist _________________

How did you hear about our office? ___________________________

Patient's Medical Information

Pediatrician/Physican ________________________ Phone ( ) ________________ Any history of the **following:**

Allergies (Incl: medication,environmental & food) ______________________________ Y ___ N___

Epilepsy	Y ___	N___	Autism/Asperger's	Y ___	N ___
HIV Positive	Y ___	N ___	Convulsions	Y ___	N ___
Blood Disorders	Y ___	N ___	Cerebral Palsy	Y ___	N ___
Anemia	Y ___	N ___	Down Syndrome	Y ___	N ___
Excessive Bleeding	Y ___	N ___	Emotional Problem	Y ___	N ___
Leukemia	Y ___	N ___	Learning Disability	Y ___	N ___
Cancer	Y ___	N ___	Attention Def. Dis and/or ADHD	Y ___	N ___
Hepatitis	Y ___	N ___	Speech Impediment	Y ___	N ___
Liver Disease	Y ___	N ___	Hearing Problem	Y ___	N ___
High Blood Pressure	Y ___	N ___	Diabetes	Y ___	N ___
Rheumatic Fever	Y ___	N ___	Skin Problem	Y ___	N ___
Heart Problem	Y ___	N ___	Tuberculosis	Y ___	N ___
Asthma	Y ___	N ___	Tumors	Y ___	N ___
Kidney Disease	Y ___	N ___	Diagnostic Testing	Y ___	N ___
Medications, ______________	Y ___	N ___	Shunts, type? ____________	Y ___	N ___

Other: ________________________

Permission to use your child's full name & photo taken in our office, on our website or for use in our office? Yes / No

Parent Signature ______________________________ Date ____________________

Patient Information Updates

Patient's Name ______________________
Has your dental insurance changed? Y or N If yes, please write the current information and give your card to the Front Desk so that we may make a copy.

____

Has your child's medical history changed? Y or N If yes, please explain.

____
Is your child on any medications? If yes, name and dosage? _______________________________
Comments: ____
____
Signature: _________________________________ Date _______________

____
Patient's Name ______________________
Has your dental insurance changed? Y or N If yes, please write the current information and give your card to the Front Desk so that we may make a copy.

____

Has your child's medical history changed? Y or N If yes, please explain.

____
Is your child on any medications? If yes, name and dosage? _______________________________
Comments: ____
____
Signature: _________________________________ Date _______________

____
Patient's Name ______________________
Has your dental insurance changed? Y or N If yes, please write the current information and give your card to the Front Desk so that we may make a copy.

____

Has your child's medical history changed? Y or N If yes, please explain.

____
Is your child on any medications? If yes, name and dosage? _______________________________
Comments: ____
____
Signature: _________________________________ Date _______________

____
Patient's Name ______________________
Has your dental insurance changed? Y or N If yes, please write the current information and give your card to the Front Desk so that we may make a copy.

____

Has your child's medical history changed? Y or N If yes, please explain.

____
Is your child on any medications? If yes, name and dosage? _______________________________
Comments: ____
____
Signature: _________________________________ Date _______________