Just for Kids
Dentistry of Forney

Dentistry for Infants, Children and Teenagers
Board Certified Specialists in Pediatric Dentistry

ACQUAINTANCE RECORD Date _____

We sincerely welcome you and your child into our practice. We will make your dental visits as pleasant as we can. In order for us to better understand your child, please complete this form as thoroughly as possible. Thank you.

Child's name _____ Nickname _____

Date of birth _____ Age _____ ❑ Male ❑ Female Weight _____

Child's Social Security number _____

Father's name _____ Date of birth _____

Social Security number _____ Driver's License number _____

Home address _____ City _____ Zip _____

Telephone (home) _____ Telephone (work) _____ Ext. _____ Fax _____

Email _____ Other _____ Best time to call _____

Mother's name _____ Date of birth _____

Social Security number _____ Driver's License number _____

Home address _____ City _____ Zip _____

Telephone (home) _____ Telephone (work) _____ Ext. _____ Fax _____

Email _____ Other _____ Best time to call _____

INSURANCE INFORMATION

Insured name _____ Employer _____

Group number _____ Insurance company _____

Insurance company telephone _____

Are parents divorced, separated, remarried, or deceased? ❑ Yes ❑ No If yes, please explain _____

_____

Who is the child's legal guardian? _____

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

Name of siblings? (circle those we have treated) _____

_____

Child's physician _____ Date of last visit _____

Names of child's favorite (pet, toy, friend, etc.) _____

_____

What is your main concern for this visit? _____

_____

PLEASE TURN OVER THIS FORM AND COMPLETE THE OTHER SIDE.

DENTAL HISTORY

Is this your child's first visit to our office? ❑ Yes ❑ No

Has your child been seen in any other dental office? ❑ Yes ❑ No

If so, where _____

Date of last dental exam _____ Last X-rays _____

Has your child experienced any unfavorable reaction from any previous medical or dental care? (state which) _____

_____

Does your child have any mouth habits such as finger sucking? ❑ Yes ❑ No If so, what? _____

_____

Does your child brush every day? ❑ Yes ❑ No

Do you assist with brushing or flossing? ❑ Yes ❑ No

Is your child still breast or bottle feeding? ❑ Yes ❑ No (please circle which)

MEDICAL HISTORY

Has your child ever been diagnosed with heart disease or heart murmur? ❑ Yes ❑ No

Does your child have any shunts, pins, screws, rods, or artificial joints? ❑ Yes ❑ No

Has your child ever had surgery? ❑ Yes ❑ No If so, what? _____

Is your child in good general health? ❑ Yes ❑ No

Has your child had or does he/she have now:

	YES	NO		YES	NO
Birth defects	❑	❑	Asperger's Syndrome	❑	❑
Cleft lip or palette	❑	❑	Sensory processing disorder	❑	❑
Food or pollen allergies	❑	❑	Diabetes	❑	❑
Allergic reaction to medication	❑	❑	Heart disease or heart murmur	❑	❑
If so, what? _____			Rheumatic fever	❑	❑
Is your child taking any medication now?	❑	❑	Hepatitis	❑	❑
If so, what? _____			Epilepsy or any seizure disorder	❑	❑
Difficulty with speech	❑	❑	Cerebral palsy	❑	❑
Hearing loss	❑	❑	Prolonged bleeding or hemophilia	❑	❑
Kidney problems	❑	❑	Leukemia	❑	❑
Asthma or lung problems	❑	❑	Tumors or malignancies	❑	❑
Emotional, mental or nervous problems (ADD / ADHD)	❑	❑	Mouth injuries	❑	❑
Autism	❑	❑			

Any other health problems we should be aware of? _____

_____

Person to contact in case of emergency (not living at home)

Name _____ Relationship _____

Address _____ City _____ Zip _____

Telephone (home) _____ Telephone (work) _____

In order to provide your child with optimum care, we draw upon the knowledge of our entire staff of doctors in consultation, diagnosis and treatment of all patients. The undersigned hereby authorizes this dental office to perform the examination and after explanation, the necessary dental services deemed appropriate for the care of the above named child and furthermore, will be responsible for charges incurred from said dental patient.

Parent signature _____ Date _____