JED KESLER
FAMILY DENTISTRY

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

**1. Tell us About Your Child**

Today's Date:_____

Child's Name:_____

Nickname:_____ Male_____ Female_____

Child's Birthdate:____/____/____/ Child's Age:_____

School:_____ Grade:_____

Child's Home #: (___)_____ SS#:_____

Child's Home Address:

_____

_____

Email Address: _____

**2. Who Is Accompanying The Child Today?**

Name:_____ Relation:_____

Do you have legal custody of this child? Yes:__ No:__

Whom may we Thank for referring you? _____

Other family members seen by us:_____

_____

Previous/Present Dentist:_____

Last Visit Date:_____

__Single __Widowed __Partnered

Parent's Marital Status: __Married __Divorced __Separated

**3. Mother's Information**: ___Step Mother ___Guardian

Name:_____ Birthdate:____/____/____

Email Address:_____

Cell #: (___)_____ Hm #: (___)_____

Employer:_____ Wk #: (___)_____

SS #: _____ DL #:_____

___Father's Information: __Step Father __Guardian

Name:_____

Email Address:_____

Cell #: (___)_____ Hm #: (___)_____

Employer:_____ Wk #: (___)_____

SS #: _____ DL #:_____

**4. Person Responsible For Account**

Name:_____ Relation:_____

Billing Address:_____

_____

Wk #: (___)_____Ext:_____ Hm #: (___)_____
Employer:_____
DL #:_____ SS#:_____
Who is responsible for making appointments?
Name:_____
Wk #: (___)_____ Ext:____ Hm #: (___)_____

**5. Primary Dental insurance**
Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #: (___)_____
Group # [Plan, Local, or Policy #]:_____
Policy Owner's Name:_____
Relationship's to Patient:_____
Policy Owner's Birthdate:_____/_____/_____ ID #:_____
Policy Owner's Employer:_____
Orthodontic Coverage? __Yes __No

**Secondary Dental Insurance**
Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #: (___)_____
Group # [Plan, Local, or Policy #]:_____
Policy Owner's Name:_____
Relationship's to Patient:_____
Policy Owner's Birthdate:_____/_____/_____ ID #:_____
Policy Owner's Employer:_____
Orthodontic Coverage? __Yes __No

**6. Why did you bring the child to the dentist today?** _____
_____
Has the child ever had a serious / difficult problem associated
with previous dental work? _____Yes _____No
Is the child's water fluoridated? _____Yes _____No
Is the child taking fluoridated supplements? _____Yes _____No
Has the child ever had any pain / tenderness in his / her
Jaw joint (TMJ/ TMD)? _____Yes _____No
Does the child brush his / her teeth daily? _____Yes _____No
Floss his / her teeth daily? _____Yes _____No
Child's Physician:_____
Phone #:_____ Date of last Visit:_____
Is the child currently under the care of a physician? _____Yes _____No

Please describe the child's current physical health:
____Good ____Fair ____Poor
Has the child ever taken Phen-Fen? _____Yes _____No
(also known as Redux or Pondimin) if so, when? _____

**Please List all prescription / over the counter or herbal supplement drugs that the child is currently taking:**

_____

_____

**Aside from items below, list all drugs/material that the child is allergic to:** _____

_____

Latex? ___Yes ___No Metals/Nickel? ___Yes ___No Plastic? ___Yes ___No

**7. Has the child ever had any of the following medical problems?**

Y N Abnormal Bleeding
Y N ADD / ADHD
Y N Any Hospital Stays
Y N Any Operations
Y N Artificial Bones / Joints
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions / Epilepsy
Y N Diabetes
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV+ / AIDS
Y N Kidney / Liver Problems
Y N Rheumatic / Scarlet Fever
Y N Sickle Cell Disease / Traits
Y N Tuberculosis (TB)

Please discuss any serious medical problems that the child has had:_____

**8. Does/did the child experience any of the following?**

Y N Lip Sucking / Biting
Y N Speech Problems
Y N Nail Biting
Y N Thumb / Finger Sucking
Y N Mouth Breather
Y N Tongue Thrust
Y N Nursing Bottle Habits
Y N Clenching / Grinding Teeth

**9.** I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorized the dental staff to perform the necessary dental service my child may need.

_____

Signature of parent or Guardian Date

**OFFICE USE ONLY**

I verbally reviewed the medical / dental information above
With the parent / guardian & patient named here in.
Initials:_____ Date:_____

**Doctor's Comments**

_____
_____
_____

**Medical History Update**

1. Date:_____ Signature:_____
Comments:_____
_____
_____
_____

2. Date:_____ Signature:_____
Comments:_____
_____
_____
_

_____