## Dentistry for KiDDS Welcome

ا ح ا	Patient Name:		Da	Date:	
nformation			MI D: II D I		
	Nickname: Mother Name:				
	Phone (Home):(Work):			to cair	
먑	Address:		Apartment #		
ᆸ	City	State	Zip Co	de	
atient	Whom may we thank for re		·		
Pat	In case of emergency who	should be notified?	Phone:		
"	First Names of Child's Siblings		ild's School:		
H					
nce	Person Responsible for Acco	ount:	First Name	MI	
ا <u>چ</u> ا			:Soc. Sec.#:		
≌	Address (if different from patie				
Insura	City:				
	Person Responsible Employ				
r/	Business Company:				
rima	Insurance Company:				
<u>₹</u>	Contract #:				
۵	Name of other dependents	covered under this plan:			
6)					
Ĕ	Is patient covered by additional insurance? 🔲 Yes 🔲 No				
<u>                                   </u>	Subscriber Name:				
Insurance	Address (if different from patie				
	City:				
itional	Subscriber Employed By:				
	Insurance Company: Contract #:				
Add	Name of other dependents	·			
	Name of other dependents	Covered under this plan.		_	
History	Reason for today's visit:				
	Former Dentist:				
	Address:				
	Date of last dental care: Date		Date of last dental X-rays		
	Is your child's water fluoridated?  Yes No Is your child taking any fluoride supplements? Yes No Has your child ever had any jaw pain or tenderness? Yes No		Has your child seen a pediatric dentist before?  Yes No If yes, the approximate month and year of last visit: Where? Has your child ever had any complications following dental		
a l					
Dental	Does your child brush their teeth da	illy?	treatment? ☐ Yes ☐ No If yes, please explain:		
	Does your child floss their teeth daily? ☐ Yes ☐No		Family Dental History: Circle appropriate parent, if yes		
	How often do they floss? How often do they brush?		Has Mother or Father had a lot of decay? Has Mother or Father had orthodontic care?		
	orean do ency brasin.		Does Mother or Father have period		