Prairie kids dental

Kimberly M. Gill, DDS, MS, LTD

New Patient Form

About Your Child

Child's Name

Name Child Prefers To Be Called

Age Gender Date of Birth

Address Apt

City State Zip

School Name / Grade

Interests/Pets

Referred to our office by: (We wish to thank them)

Name/Address/Cell Phone #

Dental History

❑ Yes ❑ No Is this your child's first visit to the dentist? **If no, when was the last visit and what was done for your child?**

❑ Yes ❑ No Do you expect your child to be a cooperative patient? **If no, please explain.**

❑ Yes ❑ No Does your child still have a night time bottle or sip cup?

❑ Yes ❑ No Does your child have a toothache?

❑ Yes ❑ No Has your child ever had trauma to the mouth or teeth?

Does your child have (or had) any of the following?

❑ Thumb Sucking How Long?_____ Still Active ❑ Yes ❑ No

❑ Finger Habit How Long?_____ Still Active ❑ Yes ❑ No

❑ Pacifier How Long?_____ Still Active ❑ Yes ❑ No

How often does your child brush?_____

Is toothbrushing supervised? ❑ Yes ❑ No

By whom?_____

Is dental floss used? ❑ Yes ❑ No

Does your child receive: ❑ Fluoride tablets/drops ❑ Tap water ❑ Bottled water ❑ Well water

Medical History

Is your child presently under the care of a physician for any medical reason, other than routine visits?

❑ Yes ❑ No If yes, explain _____

Physician's Name:_____

Address: _____

Phone Number:_____

- Is your child in good health? If no, explain _____ ❑ Yes ❑ No
- Does your child have any drug allergies? ❑ Yes ❑ No
  If yes, explain_____
- Is your child taking any medications at this time? ❑ Yes ❑ No
  If yes, list. _____
- Has your child ever been hospitalized or treated in an emergency room? ❑ Yes ❑ No
  When and for what reason?_____
- Does your child have (or had) any emotional, mental or nervous disorders? If yes, please explain. ❑ Yes ❑ No
- Have your child's tonsils and/or adenoids been removed? ❑ Yes ❑ No
- Does your child breathe through the mouth? ❑ Yes ❑ No
  If yes, ❑ Seldom ❑ Often

Please indicate if your child has had any of the following:

❑ Allergy to Penicillin
❑ Anemia
❑ Asthma
❑ Autism
❑ Bleeding disorder
❑ Bone disorder
❑ Cleft palate
❑ Diabetes
❑ Endocrine disorder
❑ Epilepsy, seizures
❑ Hyperactivity/ADD/ADHD
❑ Heart ailment or murmur
Type, if known_____
❑ Latex allergy/sensitivity
❑ Liver problems or hepatitis
❑ Malignancies or leukemia
❑ MRSA
❑ Physical handicap
❑ Positive for H.I.V.
❑ Premature birth
❑ Radiation treatment
❑ Rheumatic fever
❑ Pregnancy
❑ Sickle cell (or trait)
❑ Speech problem
❑ Tuberculosis
❑ Vision Impairment
❑ Other_____

Is child under the care of a cardiologist or special physician for a condition? If so, whom _____

Phone _____

Additional comments:_____

Responsible Party

Father's Full Name/Guardian/Stepfather

Address Apt

City State Zip

SS# Birth date

Home Phone Cell Phone

Business Phone Employer

Occupation Email Address

Dental Insurance: ❑ Yes ❑ No

Insurance Company Group or Plan Number

Insurance Company Phone

Mother's Full Name/Guardian/Stepmother

Address Apt

City State Zip

SS# Birth Date

Home Phone Cell Phone

Business Phone Employer

Occupation Email Address

Dental Insurance: ❑ Yes ❑ No

Insurance Company Group or Plan Number

Insurance Company Phone

Mobile number or email we may use for appointment reminders

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I accept responsibility for payment of services rendered for _____ (child's name). I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays and examinations) before that treatment is performed.

SIGNED (parent or legal guardian)

DATE: _____

Nearest Relative/Contact

Name

Address Apt

City State Zip

Phone Relationship

Financial Information

Method of Payment

Please check one:

❑ Check or cash at time of treatment

❑ Visa, MasterCard, American Express or Discover

❑ Insurance form with co-payment (if applicable) at time of treatment

❑ Other: _____

- Payment is expected at time of treatment.
- For patients with dental insurance we will file the claim for you at no charge, however, we ask that any deductibles or estimated portions be paid at time services are rendered. Please note, your dental insurance is designed to be of assistance to you and may not always cover the total cost(s).
- Parents with insurance may pay their estimated portion, including deductible, at the time of service. Any insurance balance over 60 days is due and payable by you.
- If your child will be treated under general anesthesia by Dr. Gill, any co-pay or out-of-pocket cost must be paid in advance of scheduling the surgery appointment.
- All insurance benefits are assigned to Kimberly M. Gill, DDS, MS, LTD.
- For your convenience, we accept cash, check, Visa, MasterCard, Discover or Care Credit (www.carecredit.com).
- For treatment costs over $500, special financing may be discussed with our administrative staff.

SIGNED (Guarantor)