myKIDSdds
Dentistry for Children & Orthodontics

Dentistry for Children
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CHILD'S FULL NAME		PREFERRED NAME	
BIRTHDATE	AGE	WEIGHT	SEX
STREET	CITY	STATE	ZIP
HOME PHONE	EMAIL ADDRESS		
SCHOOL	DISTRICT		GRADE
NAME(S) AND AGE(S) OF SIBLING(S)			
FAVORITE PLAYMATE, PET, TOY, HOBBY, OR SPORT			

HOW, OR FROM WHOM, DID YOU HEAR ABOUT OUR PRACTICE?

IS THIS YOUR CHILD'S FIRST VISIT TO A DENTIST? YES NO
IF NOT, PLEASE SHARE WHY YOU WOULD LIKE TO MAKE A CHANGE

DATE OF LAST VISIT	DENTIST

HOW WOULD YOU DESCRIBE YOUR CHILD'S PREVIOUS MEDICAL OR DENTAL EXPERIENCES?

PLEASE DISCUSS YOUR EXPECTATIONS AND DESIRES REGARDING YOUR CHILD'S DENTAL CARE

DOES YOUR CHILD HAVE REGULAR MEDICAL EXAMINATIONS? YES NO

PHYSICIAN	DATE OF LAST EXAM
ADDRESS	PHONE #
IS YOUR CHILD TAKING ANY MEDICATION(S)? YES NO	IF SO, PLEASE EXPLAIN
HAS YOUR CHILD EXPERIENCED UNFAVORABLE REACTION TO ANY MEDICATION(S)? YES NO	IF SO, PLEASE EXPLAIN

IS YOUR CHILD ADOPTED YES NO

PLEASE INDICATE ANY CONDITION(S) YOUR CHILD HAS/HAS HAD

_____ CHICKEN POX	_____ CONVULSIONS	_____ RHEMATIC FEVER	_____ CEREBRAL PALSY	_____ SMALL POX
_____ EPILEPSY	_____ MEASLES	_____ HEART CONDITION	_____ KIDNEY DISEASE	_____ ANEMIA
_____ NERVOUSNESS	_____ ASTHMA	_____ BLOOD DISORDER	_____ TUMORS	_____ OTHER:
_____ DIABETES	_____ MUMPS	_____ EMOTIONAL PROBLEMS		

PLEASE NOTE ANY SPECIAL INFORMATION ABOUT YOUR CHILD

PARENT #1 NAME	BIRTHDATE	PREFERRED NAME
HOME ADDRESS (IF DIFFERENT FROM CHILD'S)		
HOME PHONE / WORK / CELL		
OCCUPATION	EMPLOYER	HOW LONG?
SOCIAL SECURITY #	DRIVER'S LICENSE #	

PARENT #2 NAME	BIRTHDATE	PREFERRED NAME
HOME ADDRESS (IF DIFFERENT FROM CHILD'S)		
HOME PHONE / WORK / CELL		
OCCUPATION	EMPLOYER	HOW LONG?
SOCIAL SECURITY #	DRIVER'S LICENSE #	

CHILD'S PARENTS ARE MARRIED DIVORCED SEPARATED NOT MARRIED

IF PARENTS DO NOT LIVE TOGETHER, WITH WHOM DOES THE CHILD LIVE?

EMERGENCY CONTACT

RELATIONSHIP	PHONE

IT IS OUR POLICY TO INFORM YOU THAT PAYMENT OF FEES FOR PROFESSIONAL SERVICES IS EXPECTED AT THE TIME OF TREATMENT BY THE PARENT OR GUARDIAN IN ATTENDANCE. WE ACCEPT PAYMENT BY CHECK OR CASH. FOR THOSE WISHING THE CONVENIENCE OF EXTENDED PAYMENT PLANS, WE ALSO ACCEPT PAYMENT BY MASTERCARD, VISA, NOVUS/DISCOVER, AND AMERICAN EXPRESS.

BECAUSE THIS CHILD IS A MINOR, IT BECOMES NECESSARY THAT PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY NECESSARY DENTAL TREATMENT IS BEGUN. AUTHORIZATION IS HEREBY GRANTED AS SUCH.

PERMISSION IS HEREBY GRANTED TO DR. KOGUT AND ASSOCIATES TO SHARE INFORMATION WITH OTHER HEALTH CARE PROVIDERS REGARDING MY CHILD'S TREATMENT. FURTHERMORE, I WILL BE RESPONSIBLE FOR ANY FEES FOR PROFESSIONAL SERVICES RENDERED ON BEHALF OF THIS CHILD.

SIGNATURE _____ DATE _____

RELATIONSHIP TO CHILD _____