Dentistry for Children
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CHILD'S FULL NAME			PREFERRED NAME	
BIRTHDATE	AGE		SEX	
STREET	CITY		STATE	ZIP
PREFFERED PHONE NUMBER	EMAIL ADDRESS			
WHAT WAS THE GESTATIONAL AGE OF YOUR BABY AT BIRTH?				
BIRTH WEIGHT	CURRENT WEIGHT			
NAME(S) AND AGE(S) OF SIBLING(S)				

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

PLEASE DISCUSS YOUR EXPECTATIONS AND DESIRES REGARDING YOUR CHILD'S VISIT

PEDIATRICIAN			DATE OF LAST EXAM
ADDRESS			PHONE #
LACTATION CONSULTANT			DATE OF LAST EXAM
ADDRESS			PHONE #
HAS YOUR CHILD HAD PRIOR SURGERY TO CORRECT A TONGUE/ LIP TIE?	YES	NO	IF SO, PLEASE EXPLAIN
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
DOES YOUR CHILD HAVE ANY PHYSICAL OR MEDICAL CONDITIONS?	YES	NO	IF SO, PLEASE EXPLAIN
DID YOUR CHILD RECIEVE A VITAMIN K SHOT AT BIRTH?	YES	NO	

BABY'S SYMPTOM(S)			MOM'S SYMPTOM(S)
____ SUSPECTED TONGUE TIE	____ COLIC SYMPTOMS	____ NURSING FOR AN EXTENDED PERIOD OF TIME	____ CRACKED, BRUISED, BLISTERED NIPPLES
____ SUSPECTED LIP TIE	____ REFLUX SYMPTOMS	____ WEAK SUCK	____ BLEEDING NIPPLES
____ POOR LATCH	____ POOR WEIGHT GAIN	____ CLICKING NOISE WHEN NURSING	____ SEVERE PAIN DURING LATCHING
____ SLIDES OFF NIPPLES	____ WEIGHT LOSS	____ GAS	____ POOR OR INCOMPLETE BREAST DRAINAGE
____ GUMMING OR CHEWING OF NIPPLES	____ NURSING FREQUENTLY		____ INFECTED NIPPLES OR BREAST

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 ______________________________