myKIDSdds
Dentistry for Children & Orthodontics

Dentistry for Children
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CHILD'S FULL NAME		PREFERRED NAME	
BIRTHDATE	AGE	SEX	
STREET	CITY	STATE	ZIP
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	
DO YOU (MOM) OR YOUR CHILD HAVE A LATEX ALLERGY?	YES	NO	

BABY'S SYMPTOM(S)

_____ SUSPECTED TONGUE TIE
_____ SUSPECTED LIP TIE
_____ POOR LATCH
_____ SLIDES OFF NIPPLES
_____ GUMMING OR CHEWING OF NIPPLES
_____ COLIC SYMPTOMS
_____ REFLUX SYMPTOMS
_____ POOR WEIGHT GAIN
_____ WEIGHT LOSS
_____ NURSING FREQUENTLY
_____ NURSING FOR AN EXTENDED PERIOD OF TIME
_____ WEAK SUCK
_____ CLICKING NOISE WHEN NURSING
_____ GAS

MOM'S SYMPTOM(S)

_____ CRACKED, BRUISED, BLISTERED NIPPLES
_____ BLEEDING NIPPLES
_____ SEVERE PAIN DURING LATCHING
_____ POOR OR INCOMPLETE BREAST DRAINAGE
_____ INFECTED NIPPLES OR BREAST

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

PARENT #2 NAME	BIRTHDATE	PREFERRED NAME
HOME ADDRESS (IF DIFFERENT FROM CHILD'S)		
HOME PHONE/CELL	EMAIL ADDRESS	
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 _____