

Thorson Dentistry for Kids
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Tell Us About Your Child

Today's Date _____ Child's Home Phone # _____ Soc. Security # _____
Child's Name _____ Child's DOB ____/____/____ Child's Age _____
Nickname _____ Male/Female School _____ Grade _____
Child's Home Address _____
Who may we thank for referring you? _____
E-mail _____

Parent's Information

Parent's Marital Status: Married Divorced Separated Widowed Remarried Single

Mother: Birthdate: ____/____/____ Home Phone (____) _____ Work # (____) _____ Cell # (____) _____
Name _____ SSN _____ Driver's License # _____
Address _____
Employer _____ Length of Employment _____
Father: Birthdate: ____/____/____ Home Phone (____) _____ Work # (____) _____ Cell # (____) _____
Name _____ SSN _____ Driver's License # _____
Address _____
Employer _____ Length of Employment _____

Insurance Information

Primary Insurance: Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical? Yes No
Insurance Co. _____ Phone # (____) _____ Group # (plan, local or policy#) _____
Insurance Company Address _____
Insured's Name _____ Relationship to Child _____
Insured's Birthdate ____/____/____ SSN _____ Insured's Employer _____
Secondary Insurance: Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical? Yes No
Insurance Co _____ Phone # (____) _____ Group # (plan, local, or policy) _____
Insurance Company Address _____
Insured's Name _____ Relationship to Child _____
Insured's Birthdate ____/____/____ SSN _____ Insured's Employer _____

Dental History

Is the child currently in pain? Yes No What is the primary reason for today's visit? _____

Has the child experienced problems with previous dental treatment? Yes No

Does the child brush his/her teeth daily? Yes No Who does the brushing? Child Mother Father

Does the child floss daily? Yes No

Does child drink..... tap water bottled water (_____) well water? Is the water fluoridated? Yes No

Does the child take a fluoride supplement? Yes No If yes, does _____

What brand of toothpaste does the child use? _____

Previous Dentist's Name _____ Date of Last Visit? _____

Why did you leave the previous dentist? _____

Does your child have any of the following habits?:

Y N Lip Sucking/Biting Y N Clenching/Grinding Y N Tongue/Cheek Biting Y N Mouth Breather

Y N Nail Biting Y N Thumb/Finger Sucking Y N Pacifier Y N Speech Problem

Y N Chewing on Objects Y N Nursing Bottle Habits Y N Tongue Thrust Y N Breast Fed

Medical History

Child's Physician _____ Phone # _____ Date of Last Visit _____

Address _____

Is the child currently under the care of a physician? Yes No Please explain _____

Please describe the child's current physical health: Good Fair Poor Are Immunizations Current? _____

Please list all drugs your child is currently taking: _____

Please list all drugs and /or things that cause your child to have an allergic reaction _____

Anything you would like to discuss in private? Yes No

Has the child had any/experienced the following:

Y N Abnormal Bleeding Y N Chicken Pox Y N Hepatitis Y N Mononucleosis

Y N AIDS/HIV+ Y N Congenital Heart Defect Y N High Blood Pressure Y N Rheumatic Fever

Y N Allergies Y N Convulsions Y N Hives Y N Scarlet Fever

Y N Anemia Y N Diabetes Y N Kidney Problems Y N Sickle Cell

Y N Any Hospital Stays Y N Epilepsy Y N Liver Problems Y N Skin Rash

Y N Any Operations Y N Handicaps/Disabilities Y N Low Blood Pressure Y N Tonsillitis

Y N Asthma Y N Hearing Problems Y N Lupus Y N Tuberculosis

Y N Blood Transfusions Y N Heart Murmur Y N Measles

Y N Cancer Y N Hemophilia Y N Mitral Valve Prolapse

Please discuss any serious medical problems the child experience (s) (ed): _____

Authorization

I affirm that the above information I have given is correct and to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign the doctor all insurance benefits. I understand that I am responsible for payment of services rendered and any deductible and co-pay that my insurance does not cover. All accounts referred to an outside collection agency will be charged an additional 30% collection fee or attorney's fee payable by parent or guardian.

Signature _____ Date _____

