Thorson Dentistry for Kids
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Tell Us About Your Child

Today's Date ____ Child's Home Phone # ____

Child's Name ____ Child's DOB_______/_______/________ Child's Age ________________________

Nickname _______________________________ Male / Female School________________________________ Grade ________________________________

Child's Home Address ____

How did you find out about us? ____

E-mail____

Parent's Information

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

Guardian #1: Birthdate: _____/_____/______ Home Phone (_______) _______________ Work #(________) _________________ Cell # (_____) _________________

Name ____ SSN __________________________________ Driver's License #__________________________________

Address____

Employer ____ Length of Employment ___________________________

Guardian #2: 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 / Guardian #1 / Guardian #2

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): ______________________________

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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 ____________________