For a Lifetime of Smiles!

Jaime K. Marchi, D.D.S.
Just Kids Dental, S.C.

Responsible Party

FATHER OR MALE CARETAKER'S FULL NAME

RELATIONSHIP TO CHILD

ADDRESS

CITY STATE ZIP

SS# DOB

HOME PHONE NO. BUSINESS PHONE NO.

EMPLOYER OCCUPATION

EMAIL ADDRESS

MOTHER OR FEMALE CARETAKER'S FULL NAME

RELATIONSHIP TO CHILD

ADDRESS

CITY STATE ZIP

SS# DOB

HOME PHONE NO. BUSINESS PHONE NO.

EMPLOYER OCCUPATION

EMAIL ADDRESS

ADDITIONAL CHILDREN IN THE FAMILY

NAME DOB

NAME DOB

NAME DOB

NAME DOB

Nearest Relative / Friend

NAME PHONE

ADDRESS

RELATIONSHIP

REVIEWED BY DOCTOR:

Referral Information

REASON FOR TODAY'S VISIT

IF REFERRED TO US, WHO MAY WE THANK?

FULL NAME

PHONE

Dental Insurance

PRIMARY INSURANCE GROUP NO.

POLICY HOLDER NAME MEMBERSHIP NO.

SECONDARY INSURANCE GROUP NO.

POLICY HOLDER NAME MEMBERSHIP NO.

DO YOU HAVE WISCONSIN MEDICAL ASSISTANCE? Y ◯ N ◯

Authorization

THE PERMISSION OF PARENT OR GUARDIAN IS NECESSARY FOR DENTAL TREATMENT OF A MINOR:

I give the doctor's permission to use such measures as deemed necessary in their professional judgement to render a diagnosis for my child. This would include an oral examination, radiographs (X-Rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any conditions relating to my child's health or any other physical conditions that my child's medical doctor has advised me should be reported to the dentist.

I understand that I am responsible for all charges incurred to me or my family regardless of insurance coverage and that PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. If my account requires servicing by a collection agency or by an attorney I understand that I will be liable for the collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I authorize the release of any dental information necessary to process any future claims.

SIGNATURE

RELATIONSHIP TO CHILD DATE

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About Your Child

CHILD'S NAME ______ ○ M ○ F

NAME PREFERED AGE DATE OF BIRTH

SOCIAL SECURITY NUMBER WEIGHT HEIGHT

Preventative Dental History

HOW OFTEN DOES YOUR CHILD BRUSH?

IS TOOTHBRUSHING SUPERVISED? ○ Y ○ N

BY WHOM? ______

IS DENTAL FLOSS USED? ○ Y ○ N

DOES YOUR CHILD RECEIVE:
o Fluoride in vitamins o Fluoride in tablets/drops o Fluorinated water
o Bottled water o Well water

Dental History

CHILD'S FIRST DENTAL VISIT? ○ Y ○ N

PREVIOUS DENTIST CITY

DATE OF LAST VISIT

DATE OF LAST DENTAL X-RAYS

ANY INJURIES TO CHILD'S TEETH OR JAWS?
○ Y ○ N WHEN? ______

ANY RECENT DENTAL PAIN?

______

______

HISTORY OF:
- BREAST FEEDING ______
- BOTTLE HABITS ______
- THUMB/FINGER SUCKING ______
- PACIFIER ______
- DENTAL GRINDING/CLENCHING ______
- PAIN IN JAW JOINTS ______

HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL/DENTAL CARE?
○ Y ○ N (IF YES, PLEASE EXPLAIN)

______

______

HOW DO YOU THINK YOUR CHILD WILL ACT TOWARD THE DENTIST? ______

Medical History

DOES YOUR CHILD HAVE A HISTORY OF HEALTH PROBLEMS? Y O N O
IF YES, PLEASE EXPLAIN ______

______

PHYSICIAN/PEDIATRICIAN'S NAME ______
ADDRESS ______
PHONE NO. ______
DATE OF LAST PHYSICAL EXAM ______

IS YOUR CHILD PRESENTLY UNDER THE CARE OF A SPECIALIST FOR ANY MEDICAL REASON? Y O N O
IF YES, FOR WHAT? ______

______

SPECIALIST'S NAME ______
PHONE NO. ______

ARE ANTIBIOTICS NEEDED FOR DENTAL WORK DUE TO HEART MURMUR, HEART DEFECT, PROSTHESIS, SHUNT OR OTHER REASON? Y O N O
IS YOUR CHILD PRESENTLY TAKING ANY MEDICATIONS? Y O N O
WHAT? ______

______

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? Y O N O
FOR WHAT? ______
IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS? Y O N O
PLEASE LIST ______
IS YOUR CHILD ALLERGIC TO ANY DYES OR FOODS? Y O N O
PLEASE LIST ______
IS YOUR CHILD ALLERGIC TO ANY ENVIRONMENTAL POLLUTANTS? Y O N O
IS YOUR CHILD ALLERGIC TO METALS (SNAPS)? Y O N O
IS YOUR CHILD ALLERGIC TO LATEX? Y O N O
HAS YOUR CHILD OR ANY MEMBER OF YOUR FAMILY HAD A PROBLEM WITH A GENERAL ANESTHETIC? Y O N O

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

Y O N O ADD/ADHD
Y O N O AIDS/HIV
Y O N O Anemia
Y O N O Asthma (IF YES, WHAT TRIGGERS IT?)

______

Y O N O Autism
Y O N O Bladder conditions
Y O N O Blood disease
Y O N O Blood transfusions
Y O N O Birth defects
Y O N O Bone/joint problems
Y O N O Brain injury
Y O N O Bruising easily
Y O N O Cancer ______

______

Y O N O Cerebral palsy
Y O N O Child abuse
Y O N O Chronic adenoid/tonsil infection
Y O N O Chronic ear infections
Y O N O Cleft lip/palate
Y O N O Convulsions/seizures
Y O N O Developmentally delayed
Y O N O Diabetes
Y O N O Emotional disturbance
Y O N O Eye problem
Y O N O Excessive bleeding problem
Y O N O Excessive gagging
Y O N O Fainting or dizziness
Y O N O Growth/developmental problems
Y O N O Heart surgery
Y O N O Heart murmur/defect
Y O N O Headaches
Y O N O Hearing/speech impediments
Y O N O Hemophilia
Y O N O Hepatitis/liver disease
Y O N O High blood pressure
Y O N O Kidney disease
Y O N O Mental disability
Y O N O Mouth sores
Y O N O Nutritional deficiency
Y O N O Premature birth ______
Y O N O Psychiatric care
Y O N O Rheumatic fever
Y O N O Scoliosis
Y O N O Sickle cell anemia
Y O N O Syndrome ______
Y O N O Tuberculosis
Y O N O Other ______

______

Y O N O Do you wish to talk to the doctor privately about a special concern?

office use only

MEDICAL UPDATES: ______

______