

John P. Kenney, DDS Ltd. and Associates
Children's Dentistry in Park Ridge
WELCOME TO OUR PRACTICE

So that we may properly evaluate and treat your child, please take a few moments and carefully review and answer each of the questions on **BOTH PAGES OF THIS FORM**, Thank you.

Child's Name _____ (Boy / Girl) Nickname _____
Last First Middle Circle

Date of Birth _____ Age _____ School _____ Grade _____

Child's Address _____

Child's Residence Phone # _____ Hobbies _____

Father's Name _____ Mother's Name _____

Father's Date of Birth _____ Mother's Date of Birth _____

Father's SS# _____ Mother's SS# _____

Father's Address _____ Mother's Address _____

How Long? _____

How Long? _____

Father's E-mail Address _____ Mother's E-mail Address _____

Father's Residence Phone # _____ Mother's Residence Phone # _____

Father's Cell Phone / Pager # _____ Mother's Cell Phone / Pager # _____

Father's Occupation _____ Mother's Occupation _____

Father Employed by _____ Mother Employed by _____

How Long? _____

How Long? _____

Parental Status: (Circle) Married Remarried Separated Divorced (Joint/Sole Custody) Widow(er)
Single Step Parent Guardian

How did you hear about our office ---- Whom may we thank? _____

Names and Ages of Other Children in Family _____

DENTAL INSURANCE

Do you have Dental Insurance? Yes No

Primary Carrier (Dad/Mom) _____ Group No. _____

Secondary Carrier (Dad/Mom) _____ Group No. _____

AS PAYMENT IS DUE AT THE TIME OF SERVICE AND PAYMENT IN FULL IS DUE FOR THE INITIAL VISIT,
PLEASE INDICATE THE METHOD OF ROUTINE PAYMENT FOR YOUR ACCOUNT: (Circle)

Cash Check Visa MasterCard

DENTAL HISTORY

1. What prompted you to bring your child to our office today? _____

2. When did your child's first tooth erupt? (approximate age) _____ Similar Family History? Yes No

3. Do you desire complete dental services for you child? Yes No Explain _____

4. Name of last dentist? _____

5. Date of last visit? _____ For what services? _____

6. Child's attitude towards dentistry and doctors in general _____

7. Any unhappy dental visits? Yes No If no, why? _____

8. Has child complained about teeth? Yes No How long? _____

9. Past injury to Mouth, Teeth, Head? Yes No Explain _____

10. Oral Habits: (Circle) Thumb/Finger Sucking Nail-Biting Mouth-Breathing Pacifier Nursing/Bottle How long? _____

11. Has child ever had a problem with: (Circle) Clinching/Grinding Teeth Swelling/Lumps in Mouth Blisters/Cold Sores
Pain in or about Ears Bleeding Gums --- How long? _____ Explain _____

12. How often does child brush? _____ Does parent help with brushing? Yes No Is floss used? Yes No

13. Has child lived in a non-fluoridated area (including the prenatal period)? Yes No How long? _____

14. Was child breast fed? Yes No How long? _____ Was child bottle fed? Yes No How long? _____

Health History

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

Address _____ Reason for Visit _____

Is child currently under treatment? Yes No If no, why? _____

Is child currently or in the last 60 days taking any medication(s)? Yes No If no, why? _____

Is or was child taking **ANY** daily medications, e.g., for sinus/ear infections, bladder infections, etc.? Yes No

What medication(s)? _____

Does child bleed excessively when cut? Yes No

Has child ever been hospitalized? When? _____ Why? _____

Has child ever had surgery? When? _____ Why? _____

Is child allergic to Penicillin, Local Anesthetics, (---Caines) or other drugs? _____

Other allergies? Food/Dyes Dust Pollen Animal? _____

Does child have good physical coordination? Yes No Any emotional problems? Yes No If no, explain _____

HAS CHILD EVER HAD HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING?

ARE CHILDHOOD IMMUNIZATIONS UP-TO-DATE? (DPT/Polio, etc.) Yes No

____ ADD/ADHD	____ Cerebral Palsy	____ Epilepsy	____ HIV/AIDS	____ Mumps
____ Anemia	____ Chicken Pox	____ Eye/Vision	____ Kidneys	____ Radiation Treatment
____ Asthma	____ Chronic Sinus	____ Fainting	____ Learning Disability	____ Rheumatic Fever
____ Autism	____ Convulsions	____ Hearing	____ Malignancy	____ Sickle Cell
____ Bladder	____ Diabetes	____ Heart	____ Measles	____ Tuberculosis
____ Blood Transfusion	____ Ears/Ear Tubes	____ Hepatitis	____ Mononucleosis	____ Thyroid

Please describe any current or past family history, medical treatment, pending surgery, recent injuries or other information that the Doctor should be aware of that has not been covered on this form and may have an effect on the treatment or behavior of this child:

OFFICE POLICY / TREATMENT CONSENT

APPOINTMENTS: Each appointment represents a specific amount of time reserved for your child's dental treatment. WE realize that your time, like ours, is valuable and we endeavor to stay on time. Occasionally, due to patient emergencies we may run a bit behind. Remember that your child would get the same consideration and prompt attention. Please plan to arrive for future appointments no more than **FIVE** minutes earlier than scheduled, as your early arrival will affect other parent's schedules unfairly. Please provide us with 24 hours notice if for some URGENT reason your child is unable to keep their appointment. Appointment failures with less than 24 hours notice may incur a cancellation charge. Repeated cancellations will cause us to appoint your child at less desirable times.

INSURANCE: YOUR INSURANCE IS A CONTRACT BETWEEN **YOU AND YOUR CARRIER** SINCE EACH POLICY HAS DIFFERENT PROVISIONS AND LEVELS OF PAYMENT, AND IN ORDER TO KEEP OUR FEES REASONABLE, **WE REQUIRE THAT PAYMENT IN FULL FOR ALL CHARGES AT THE INITIAL VISIT BE MADE AT THE TIME OF SERVICE.** **We will file your insurance and they will reimburse you directly. For subsequent visits with dental insurance that is in force. We require that the estimated co-payment be made at the time of service. WITHOUT DENTAL INSURANCE WE REQUIRE PAYMENT FOR ROUTINE SERVICES, e.g., (Initial Visits, Check-ups, Cleanings, Fillings, Sealants, Pulp Therapy and Extractions) BE MADE AT THE TIME THEY ARE RENDERED.** For all **non-routine** services, we will be happy to work out a payment plan. For your convenience, we accept Visa & MasterCard.

CONSENT

I hereby certify that the foregoing information is correct and give my consent for treatment on the above named child. Furthermore, **I WILL PERSONALLY BE RESPONSIBLE FOR ANY FINANCIAL OBLIGATIONS INCURRED ON THIS CHILD FOR TREATMENT.** I understand that balances including pending insurance that are past due without prior financial arrangements may be turned over to a service bureau for collection.

I understand that in order to complete necessary dental treatment on my child certain BEHAVIOR MANAGEMENT TECHNIQUES generally accepted and used in pediatric dentistry may be necessary including the use of Voice Control, Passive Restraint, Mouth Props, Rubber Dam and/or Nitrous Oxide Analgesia. If you have any questions regarding use of these modalities, please feel free to ask the doctor. We are able to take a crying fearful child, treat them and then have them come out of the treatment area with a smile on their face. Parents will be allowed in the treatment area **AT THE DOCTOR'S DISCRETION.** We do this to give **our undivided attention to your child and to have their complete attention as well.** Thank you.

Signature

Relationship

Date