KENNEDY
DENTAL CARE
361-992-9500
info@kennedydentaltx.com

TELL US ABOUT YOUR CHILD:

Patient's Name:________________________________
Date of Birth: _______________________Age:______
Social Security #:______________________________
Nickname: ____________________ ☐Male ☐ Female
Mailing Address: ______________________________
City, State, Zip: _______________________________
Phone: _______________________________________
E-mail: _______________________________________
School: _______________________________________

FATHER'S INFORMATION:

☐ Married ☐ Single
☐ Guardian ☐ Step-Father
☐ Foster Parent

Name: ____
Social Security #: ____________________________
Date of Birth: _________________________________
Employer: _____________________________________
Work Phone: ___________________________________
Home Phone: ___________________________________
Cell Phone: ____________________________________

MOTHER'S INFORMATION:

☐ Married ☐ Single
☐ Guardian ☐ Step-Mother
☐ Foster Parent

Name: ____
Social Security #: ____________________________
Date of Birth: _________________________________
Employer: _____________________________________
Work Phone: ___________________________________
Home Phone: ___________________________________
Cell Phone: ____________________________________

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: ____
Relation: ______________________________________

Who do you allow to make a dental decision on your behalf:
Name: ____
Relationship: __________________________________
Name: ____
Relationship: __________________________________

IN CASE OF AN EMERGENCY, PLEASE CALL:

Name: ____
Phone: ____
Other family members are seen by us:
____
Name and phone # of nearest relative not living with you: ______________________________
____
Name of person who is allowed to accompany and authorize dental treatment of your child:
Name: ____
Relationship to Child: _________________________
Name: ____
Relationship to Child: _________________________
Name: ____
Relationship to Child: _________________________
Name: ____
Relationship to Child: _________________________

PERSON RESPONSIBLE FOR ACCOUNT:

Name: ____
Relation: ______________________________________
Home Phone: ___________________________________
Work Phone: ___________________________________
Cell Phone: ____________________________________

WHO MAY WE THANK FOR REFERRING YOU:

☐Patient ☐ Doctor ☐ Friend
☐ Web Site ☐Radio ☐Search Engine/ Online
☐Facebook ☐Other ________________________
Name: ____

INSURANCE INFORMATION:
ASK US IF WE ARE IN NETWORK

Insurance Company: ________________________
Insured's Name: ______________________________
Insured's Date of Birth: ______________________
Insured's Social Security #:___________________
Relationship to Patient: ______________________
Group: (Plan, Local, or Policy)_________________
For our patients with dental insurance, we will be happy to file insurance claims for you as long as your insurance can be verified. We ask you to pay
Other Doctors Child May See: ________________
____

PLEASE DESCRIBE YOUR CHILD'S CURRENT PHYSICAL HEALTH:

☐ Good ☐ Fair ☐ Poor

PRIOR SURGERIES & DATES:
____
____

PLEASE LIST ALL DRUGS THAT THE CHILD IS CURRENTLY TAKING:
____
____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

Yes	No	
☐	☐	Lip Sucking / Biting
☐	☐	Mouth Breathing
☐	☐	Nail Biting
☐	☐	Nighttime Grinding of Teeth
☐	☐	Nursing / Bottle Habits
☐	☐	Pacifier
☐	☐	Sippy Cup
☐	☐	Thumb / Finger Sucking

DOES YOUR CHILD HAVE ANY HISTORY OF A HEART CONDITION?
☐ **YES** ☐ **NO**

Cardiologist:__________________________
Phone #:______________________________

all non-covered fees as treatment progresses. If we do not receive a payment within five (5) weeks after treatment, you will be expected to pay for all dental services. In the event of a duplicate payment, you will be reimbursed.

____
Signature of Parent / Guardian Date

Previous / Present Dentist:
____
Child's Pediatrician: __________________________

DOES YOUR CHILD HAVE OR EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Yes	No	
☐	☐	ADD
☐	☐	ADHD
☐	☐	AIDS
☐	☐	Alcohol Use
☐	☐	Allergies (Latex)
☐	☐	Allergies (Food)_______________
☐	☐	Allergies (Medication)__________
☐	☐	Allergies (Seasonal)
☐	☐	Anemic
☐	☐	Anger Issues
☐	☐	Anxiety
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Autistic
☐	☐	Bipolar
☐	☐	Blood Clotting Problems
☐	☐	Cancer
☐	☐	Cerebral Palsy
☐	☐	Cleft Lip
☐	☐	Cleft Palate
☐	☐	Depression
☐	☐	Developmental Delay
☐	☐	Diabetes
☐	☐	Down's syndrome
☐	☐	Epilepsy
☐	☐	Seizures
☐	☐	Hearing Impaired
☐	☐	Hemophilia
☐	☐	Hepatitis ____________________
☐	☐	High Blood Pressure
☐	☐	HIV
☐	☐	Hospital Stays________________
☐	☐	Kidney Problems
☐	☐	Liver Problems
☐	☐	Lupus

☐	☐	Mental Disorders	☐	☐	Syndrome ____________________
☐	☐	Pre-Medication _______________	☐	☐	Tuberculosis
☐	☐	Pregnant	☐	☐	Tobacco Use
☐	☐	Rheumatic Fever	☐	☐	Vision Problems
☐	☐	Special Needs_________________			
☐	☐	Speech Impairment			
☐	☐	Stomach Problems			
☐	☐	Substance Abuse			

Other:____

Please Explain: ______________________________

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the doctors and the dental staff to perform any necessary dental services my child may need. The responsible party is the parent who brings the child to the dental office, independent of what a divorce decree may state. Reimbursement must be made between the divorced parties. We will not intervene.

****Only 1 custodial parent/caregiver will be allowed in the treatment room with the patient during treatment. Switching between custodial parents/caregivers will NOT be allowed because of distraction to the patient caused during transitions. ****

******VIDEO TAPING in the office is forbidden unless formal consent from Kennedy Dental Care has been obtained prior to treatment. CELL PHONES should be turned off or silent during preventive or restorative treatment. ******

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Signature of Parent / Guardian Date

____

Signature of Person Accompanying Child Date