RYAN S KINN DMD
FAMILY & IMPLANT DENTISTRY

Welcome!

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

PLEASE COMPLETE BOTH SIDES OF THIS FORM.

Today's Date: _____

Tell Us About Your Child

Child's Name: (*Last, First, MI*)_____

Gender: Male Female

Birthdate: _____

Nickname: _____

School:_____ Grade: _____

Child's Home #: _____

SS#: _____

Child's Home Address: _____

_____

Previous / Present Dentist: _____

Last Visit Date: _____

Parent's Marital Status: *(circle one)*

Single, Married, Widowed, Divorced, Partnered, Separated

Parent Information–*Mother, Father, Step Parent, Guardian (circle one)*

Name: _____

Birthdate: _____

Email Address: _____

Cell #: _____ Home #:_____

Employer: _____

Work #: _____

SS#: _____ DL#: _____

Mother, Father, Step Parent, Guardian (circle one)

Name: _____

Birthdate: _____

Email Address: _____

Cell #:_____ Home #: _____

Employer: _____

Work #: _____

SS#: _____ DL#: _____

Person Responsible for Account

Name: _____

Relation: _____

Billing Address: _____

_____

Cell #: _____ Home #: _____

Employer: _____

Work #: _____

SS#: _____ DL#: _____

Primary Dental Insurance

Insurance Co. Name: _____

Address: _____

_____

Phone #: _____

Group # (plan, local, or policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

Policy Owner's SS#: _____

Policy Owner's Employer: _____

Orthodontic Coverage? Yes No

Secondary Dental Insurance

Insurance Co. Name: _____

Address: _____

_____

Phone #: _____

Group # (plan, local, or policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

Policy Owner's SS#: _____

Policy Owner's Employer: _____

Orthodontic Coverage? Yes No

What is the reason for the child's visit to the dentist today?

_____

Has the child ever had a serious / difficult problem associated with previous dental work? Y N
Is the child's water fluoridated? Y N
Is the child taking fluoridated supplements? Y N
Has the child ever had any pain / tenderness in their jaw joint (TMJ / TMD)? Y N
Does the child brush daily? Y N
Does the child floss daily? Y N

Child's Physician: _____

Phone #: _____

Date of Last Visit: _____

Is the child currently under the care of a physician? Y N
Please describe the child's current physical health: Good Fair Poor
Has the child taken Fosamax, Astonel, Boniva or any other bisphosphonate? Y N

Please list all drugs that the child is currently taking (please attach list if more room required):

_____

Aside from the items listed below, list all drugs/things the child is allergic to:

Latex	Y	N	Metals/Nickel	Y	N
Plastic	Y	N			

Does/did the child experience any of the following:

Lip Sucking/Biting	Y	N
Nail Biting	Y	N
Nursing Bottle Habits	Y	N
Thumb/Finger Sucking	Y	N

Was the child breast fed? Y N

Has the child ever had any of the following medical conditions?

Abnormal Bleeding	Y	N
ADD/ADHD	Y	N
Anemia	Y	N
Hospital Stays	Y	N
Operations	Y	N
Artificial Bones/Joints/Valves	Y	N
Asperger Syndrome	Y	N
Asthma	Y	N
Autism	Y	N
Cancer	Y	N
Chicken Pox	Y	N
Congenital Heart Defect	Y	N
Convulsions	Y	N
Diabetes	Y	N
Epilepsy	Y	N
Exposed to HIV, but Neg	Y	N
Handicaps/Disabilities	Y	N
Hearing Impairment	Y	N
Heart Murmur	Y	N
Hemophilia	Y	N
Hepatitis	Y	N
Hives	Y	N
HIV+/AIDS	Y	N
Kidney/Liver Problems	Y	N
Measles	Y	N
Mononucleosis	Y	N
Rheumatic/Scarlet Fever	Y	N
Sickle Cell Disease/Traits	Y	N
Skin Rash	Y	N
Tuberculosis	Y	N

Are the child's immunizations current? Y N
Anything you would like to discuss with the doctor in private? Y N

Please discuss any serious medical problems that the child has had:

_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and 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 dental service my child may need.

Signature of Parent or Guardian: _____ **Date:_____**

My method of payment will be: _____

I certify that my child is covered by_____ insurance company and I assign directly to the dental office all insurance benefits otherwise payable to me. I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian: _____ **Date:_____**

The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein. Initials:_____ Date: _____
Doctor's comments:

Medical History Update 1. Date:_____ Signature _____
Comments:

Medical History Update 2. Date: _____ Signature: _____
Comments: