



ONLY A PARENT OR LEGAL GUARDIAN CAN THIS FORM

PLEASE TELL US ABOUT YOUR CHILD-

FIRST NAME _____ LAST NAME _____ NICKNAME _____ MALE/FEMALE _____
 DATE OF BIRTH _____ AGE _____ SCHOOL/PRESCHOOL _____ GRADE _____
 WITH WHOM DOES CHILD LIVE? _____ CHILD'S CELLPHONE _____ CHILD'S EMAIL _____
 NAME/AGE SIBLINGS _____ INTERESTS/HOBBIES _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS? (PLEASE CIRCLE ALL THAT APPLY)

LIP SUCKING/BITING NAIL BITING	THUMB/FINGER SUCKING (WHEN _____)	TONGUE/CHEEK BITING
PEN/PENCIL CHEWING	ICE CRUNCHING	GOING TO BED WITH BOTTLE
CLENCHING/GRINDING	PACIFIER	GOING TO BED WITH SIPPER
TOBACCO PRODUCTS		TONGUE THRUSTING

PLEASE TELL US ABOUT YOU-

THE PARENT/GUARDIAN WHO BRINGS THE CHILD IS RESPONSIBLE FOR THE ACCOUNT. PLEASE FILL OUT BOTH SECTIONS.
HAVE YOU RECENTLY GAINED CUSTODY OF THIS CHILD? YES/NO

MOTHER STEPMOTHER GRANDMOTHER GUARDIAN/OTHER

NAME _____ DATE OF BIRTH _____ SS# _____
 HOME PHONE # _____ CELL PHONE # _____ WORK PHONE # _____
 HOME ADDRESS _____ EMPLOYER _____
 E-MAIL ADDRESS _____

FATHER STEPFATHER GRANDFATHER GUARDIAN/OTHER

NAME _____ DATE OF BIRTH _____ SS# _____
 HOME PHONE # _____ CELL PHONE # _____ WORK PHONE # _____
 HOME ADDRESS _____ EMPLOYER _____
 E-MAIL ADDRESS _____

PLEASE TELL US ABOUT YOUR DENTAL INSURANCE-

NO DENTAL INSURANCE
 NAME OF PRIMARY DENTAL INSURANCE COMPANY _____ GROUP # _____
 INSURED'S NAME _____ EMPLOYER _____
 NAME OF SECONDARY DENTAL INSURANCE COMPANY _____ GROUP # _____
 INSURED'S NAME _____ EMPLOYER _____
 INDIANA MEDICAID # _____ CHILD'S SS#(IF MEDICAID) _____
 INDIANA CHILDREN'S SPECIAL NEEDS INSURANCE MEMBER # _____

PLEASE TELL US HOW YOU HEARD ABOUT OUR OFFICE-PLEASE CIRCLE

FRIEND/FAMILY (NAME)- _____
 OTHER DR OR DENTIST- _____
 YELLOW PAGES / BILLBOARD / DROVE BY OFFICE / NEWSPAPER / WEBSITE

PLEASE TELL US ABOUT YOUR CHILD'S MEDICAL HISTORY

CHILD'S PHYSICIAN/PEDIATRICIAN _____ CITY/STATE _____

ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? YES/NO (CIRCLE ONE)

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING?

- YES/NO HEART MURMUR / CONGENITAL HEART DEFECT
- YES/NO LIVER/STOMACH PROBLEMS
- YES/NO BLEEDING PROBLEMS
- YES/NO KIDNEY PROBLEMS
- YES/NO ADENOIDECTOMY/ TONSILLECTOMY
- YES/NO ARTHRITIS
- YES/NO FREQUENT EAR INFECTIONS
- YES/NO PREMATURE BIRTH
- YES/NO ASTHMA (DATE OF LAST ATTACK) _____
- YES/NO HEARING PROBLEMS
- YES/NO MAJOR INJURY
- YES/NO BREATHING/LUNG PROBLEMS
- YES/NO SPEECH PROBLEMS
- YES/NO SLEEP APNEA/SNORING
- YES/NO HYPERACTIVITY/ATTENTION DEFICIT DISORDER
- YES/NO VISION PROBLEMS
- YES/NO FREQUENT HEADACHE
- YES/NO HIV/AIDS

- YES/NO FREQUENT HOSPITALIZATIONS
- YES/NO CEREBRAL PALSY
- YES/NO DIABETES/ENDOCRINE PROBLEMS
- YES/NO CONGENITAL BIRTH DEFECT
- YES/NO EASILY BRUISED
- YES/NO CANCER/TUMORS/BLOOD DISEASE
- YES/NO MENTAL DELAY
- YES/NO SEIZURE DISORDER (DATE LAST SEIZURE) _____
- YES/NO RHEUMATIC FEVER
- YES/NO PHYSICAL DELAY
- YES/NO IS YOUR CHILD UNDERGOING PSYCHOLOGICAL TREATMENT OR COUNSELING? EXPLAIN _____
- YES/NO IS YOUR CHILD CURRENTLY TAKING MEDICATION OR OVER THE COUNTER DRUGS? LIST _____
- YES/NO IS YOUR CHILD CURRENTLY TAKING ANY HERBAL THERAPIES? EXPLAIN _____

ALLERGIES

- YES/NO MEDICINE ALLERGIES-LIST _____
- YES/NO LATEX ALLERGY
- YES/NO SEASONAL/ENVIRONMENTAL ALLERGIES-LIST _____
- YES/NO FOOD ALLERGIES-LIST _____
- YES/NO DYE ALLERGIES-LIST COLORS _____

PLEASE TELL US ABOUT YOUR CHILD'S DENTAL HISTORY-

- YES/NO IS YOUR CHILD HAVING ANY DENTAL PAIN?
- YES/NO IS THIS YOUR CHILD'S FIRST DENTAL VISIT? IF NOT, PREVIOUS DENTIST AND DATE _____
- YES/NO HAS YOUR CHILD EVER INJURED HIS/HER MOUTH OR TEETH, EVEN AS AN INFANT? IF YES, PLEASE EXPLAIN CIRCUMSTANCES AND AGE OF OCCURANCE _____
- AT WHAT AGE DID YOUR CHILD STOP-NURSING/BOTTLE FEEDING? _____ SIPPER CUP? _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE PRECEDING QUESTIONS AND CERTIFY TO THE TRUTH OF ALL INFORMATION GIVEN. I WILL NOT HOLD DR. WINN OR ANY MEMBER OF HER TEAM RESPONSIBLE FOR ERRORS OR OMISSIONS I HAVE MADE IN THE COMPLETION OF THIS FORM. I UNDERSTAND THAT THE INFORMATION WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES. I GIVE DR. WINN PERMISSION TO USE SUCH MEASURES AS DEEMED NECESSARY IN HER PROFESSIONAL JUDGEMENT TO RENDER A DIAGNOSIS FOR MY CHILD. ALL DIAGNOSTIC AIDS, SUCH AS X-RAYS AND MODELS, ARE THE PROPERTY OF THIS OFFICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED BY 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, I UNDERSTAND THAT I WILL BE LIABLE FOR THE COLLECTION FEES AND ANY APPLICABLE COURT COSTS, IN ADDITION TO MY OUTSTANDING BALANCE. I ALSO REQUEST THAT PAYMENT UNDER MY DENTAL INSURANCE BE MADE PAYABLE TO DR. TERRI WINN ON ANY SERVICES PROVIDED FOR MY FAMILY. I AUTHORIZE THE RELEASE OF ANY DENTAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ANY FUTURE CLAIMS. THIS AUTHORIZATION SHALL CONTINUE INDEFINITELY UNLESS REVOKED BY ME IN WRITING. THE KIDS' DENTIST DOES NOT ASSUME ANY LIABILITY FOR CHILDREN WHILE THEY ARE PLAYING ANYWHERE ON THE KIDS' DENTIST PREMISES. PARENTS/ACCOMPANYING ADULTS ARE EXPECTED TO SUPERVISE THEIR CHILDREN WHILE PLAYING. BY SIGNING BELOW, PARENT/GUARDIAN RELEASES THE KIDS' DENTIST FROM ALL LIABILITY FOR ANY INJURIES THEIR CHILD MAY RECEIVE WHILE ON THE KIDS' DENTIST PREMISES.

SIGNED _____ DATE _____

WITNESS _____

ADDITIONAL AUTHORIZATIONS

I give permission for _____, _____
Name Relationship
to authorize treatment for my child in the event I am unavailable.

Parent

Date

FINANCE

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option that you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you.

- Cash
- Personal Check
- Credit Card Visa MasterCard

Card # _____ Exp Date _____

I hereby authorize The Kids' Dentist to use the account number

Signature

Date

Additional Authorization for treatment and case discussion

I give permission for _____, _____
Name Relationship
to authorize and discuss treatment for my child _____
in the event I am unavailable.

Parent

Date