My Kids Hometown Dentist
Pediatric Dentistry

Patient Information

Child's Name_____ (male / female)
Child's Age_____ Birthday_____
Child's Home Address_____

Family Information

Mother's Information (step mother / guardian)
Name_____ Birthday_____
Address_____
Home #_____ Cell # _____Work # _____
Employer_____
Occupation_____
Social Security # _____Drivers License# _____
Email _____

Father's Information (step father / guardian)
Name_____ Birthday_____
Address_____
Home # _____ Cell # _____Work # _____
Employer_____
Occupation_____
Social Security # _____Drivers License# _____
Email _____

Primary Dental Insurance
Insurance Co. Name_____
Insurance Co. Address_____
Insurance Co. Phone_____
Group # _____ Policy #_____
Insured's Name_____
Relationship to patient_____
Insured's birthday_____ SS#_____
Insured's employer_____

Secondary Insurance
Insurance Co. Name_____
Insurance Co. Phone_____
Group # _____ Policy #_____
Insured's Name_____
Relationship to patient_____
Insured's birthday_____ SS#_____

Patient Dental / Medical History

Reason for today's visit_____
Child's former Dentist_____ __ Phone #_____ Has your child ever had an unfavorable experience in a previous dental office

_____
Is the child currently under orthodontic care (yes / no)
Child's Orthodontist . _____ Phone #_____
History of trauma to the teeth or mouth? (yes / no)
Explain_____

Child's Physician_____ Phone #_____
Has your child ever had any of the following medical condition's :

Asthma	y / n	Cancer	y / n	Hepatitis	y / n
Hemophilia	y / n	Rheumatic Fever	y / n	Allergies	y / n
Epilepsy	y / n	Tuberculosis	y / n	ADD/ADHA	y / n
Liver	y / n	Kidney	y / n	G.I.	y / n
Anemia	y / n	Red Dye	y / n	Latex	y / n
Congenital Heart Defect			y / n		

If yes to any of the above, please detail:

_____
Please describe any other medical history or problem you feel should be brought to the doctor's attention:

_____
Current Medications _____
Please list your child's allergies: _____

Authorization and Release

In accordance with HIPAA regulations, only information needed to aid in the treatment or diagnosis of your child and or to facilitate the payment of claims by a third party will be released if insurance is billed.
I authorize and request my insurance company to pay directly to Dr. Stanislawski insurance benefits otherwise payable to me. I also authorize Dr. Stanislawski and or the dental staff to perform the necessary dental services my child may need. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I understand that my dental insurance carrier may pay less than the actual services billed. I agree to be responsible for payment of all services rendered for my child, as well as any collection fees incurred in an attempt to collect any outstanding debt.

If parents do not live together, the parent or guardian that accompanies the child will be responsible for payment at each visit.

Signature of parent_____