



# WELCOME!

Thank you for choosing Hawthorne Kids Dentistry for your child's dental care!

## PATIENT INFORMATION

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  M  F  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Primary number for appointment confirmations: ( ) - \_\_\_\_\_  
 Who is accompanying the child today?  
 Name: \_\_\_\_\_ Relation:  Biological  Adopted  Foster  Nanny  Other: \_\_\_\_\_

## PARENT INFORMATION

### GUARDIAN (I)

Name: \_\_\_\_\_ Gender:  M  F  
 DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Marital Status:  Single  Married  Domestic Partnership  
 Separated  Divorced  Widowed  
 Home: ( ) - \_\_\_\_\_ Cell: ( ) - \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Check box if Address is same as patient's listed above.  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Work: ( ) - \_\_\_\_\_

### GUARDIAN (II)

Name: \_\_\_\_\_ Gender:  M  F  
 DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Marital Status:  Single  Married  Domestic Partnership  
 Separated  Divorced  Widowed  
 Home: ( ) - \_\_\_\_\_ Cell: ( ) - \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Check box if Address is same as patient's listed above.  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Work: ( ) - \_\_\_\_\_

Who does the patient live with? :  Guardian 1 & 2  Guardian 1  Guardian 2  Other: \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

### PRIMARY COVERAGE

Name of Insured: \_\_\_\_\_  
 DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Phone: ( ) - \_\_\_\_\_  
 Insurance Co.: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: ( ) - \_\_\_\_\_  
 Group/Policy #: \_\_\_\_\_  
 I.D. #: \_\_\_\_\_

### SECONDARY COVERAGE

Name of Insured: \_\_\_\_\_  
 DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Phone: ( ) - \_\_\_\_\_  
 Insurance Co.: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: ( ) - \_\_\_\_\_  
 Group or Policy #: \_\_\_\_\_  
 I.D. #: \_\_\_\_\_

## REFERRAL INFORMATION

Please share with us how you heard about our office...

- Sibling(s): \_\_\_\_\_
- Friend: \_\_\_\_\_
- Pediatrician/Physician: \_\_\_\_\_
- Dentist/Dental Office: \_\_\_\_\_
- Insurance: \_\_\_\_\_
- School/Daycare: \_\_\_\_\_
- Community Event: \_\_\_\_\_
- Google
- Website
- Facebook
- Angie's List
- Print Ad (magazine, newspaper, etc): \_\_\_\_\_
- Media Ad (radio, movie theater, etc.): \_\_\_\_\_
- Other: \_\_\_\_\_

## DENTAL HISTORY

### DENTAL CONCERNS

What is the primary reason for today's visit? :  Cleaning  Trauma/Dental Emergency  Consult for Decay

Has your child ever been to the dentist? :  Yes  No

(If Yes) Previous/Present Dentist: \_\_\_\_\_ Date Last Exam: \_\_\_\_\_ Date Last X-Rays: \_\_\_\_\_

Do you think your child will react well to treatment? :  Yes  No

Please describe any tips/tricks that will help our team provide a positive experience for your child's visit: \_\_\_\_\_

### DENTAL HABITS

Does your child currently... (check all that apply)

- Suck Thumb/Finger  Suck/Bite Lips  Bite/Chew Nails  Tongue Thrust  Bottle Feed  
 Use Pacifier  Tongue/Cheek Chew  Clench/Grind Teeth  Mouth Breather  Breast Feed

### HYGIENE ROUTINE

(check all that apply)

- Fluoride Toothpaste  Consume Fluoridated Water  Brushing by Child: \_\_\_\_/day  Snack between Meals - Type of snacks: \_\_\_\_\_  
 Fluoride Mouthwash  Dental Floss: \_\_\_\_/week  Brushing by Parent: \_\_\_\_/day \_\_\_\_\_

## MEDICAL HISTORY

Are immunizations current? :  Yes  No

Child's physician: \_\_\_\_\_ Phone: ( ) - \_\_\_\_\_ Date Last Exam: \_\_\_\_\_

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain): \_\_\_\_\_

Current Medications: \_\_\_\_\_

Has your child been diagnosed and/or treated for any of the following... (check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Blood Disorder/Anemia            | <input type="checkbox"/> Tuberculosis (TB)             | ALLERGIES:                                      |
| <input type="checkbox"/> Abnormal Bleeding/Hemophilia     | <input type="checkbox"/> Asthma/Reactive Airway        | <input type="checkbox"/> Drug: _____            |
| <input type="checkbox"/> Immune Disorder/HIV/AIDS         | <input type="checkbox"/> Tonsillitis                   | <input type="checkbox"/> Food: _____            |
| <input type="checkbox"/> Cancer/Tumor/Leukemia            | <input type="checkbox"/> Congenital Birth Defects      | <input type="checkbox"/> Seasonal               |
| <input type="checkbox"/> Heart Murmur/Defect/Surgery      | <input type="checkbox"/> Premature/Low Birth Weight    | <input type="checkbox"/> Hives                  |
| <input type="checkbox"/> Epilepsy/Seizures/Convulsions    | <input type="checkbox"/> Cleft Lip/Palate              | <input type="checkbox"/> Latex                  |
| <input type="checkbox"/> Cerebral Palsy                   | <input type="checkbox"/> Autism Spectrum               | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Cystic Fibrosis                  | <input type="checkbox"/> ADD/ADHD                      |   |
| <input type="checkbox"/> Kidney Problems                  | <input type="checkbox"/> Eating Disorder               |   |
| <input type="checkbox"/> Liver Disease/Jaundice/Hepatitis | <input type="checkbox"/> Speech Disorder               |   |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Vision Problems               |   |
| <input type="checkbox"/> Sickle Cell Trait                | <input type="checkbox"/> Hearing Problems/Deaf         |   |
| <input type="checkbox"/> Stomach/GI Disorders             | <input type="checkbox"/> Mental/Cognitive/Social Delay |   |

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand that Hawthorne Kids Dentistry may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Hawthorne Kids Dentistry all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_