Kimberly Park Dental
A·S·S·O·C·I·A·T·E·S

PATIENT INTRODUCTION
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

1 Tell us about your child

Today's Date ______________________

Child's Name ______________________
LAST FIRST MI

Nickname ______________ ☐ Male ☐ Female

Child's Birthdate ____/____/____ Child's Age ________

School ______________ Grade ________

Child's Home # ____________ SS # ____________

Child's Home Address ______________________ APT/CONDO#

____
CITY STATE ZIP

2 Who is accompanying the child today?

Name ______________ Relation ________

Do you have legal custody of this child? ☐ Yes ☐ No

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Who may we **Thank** for referring you? ______________

Other family members seen by us ______________

____

Previous / Present Dentist ______________
(PLEASE CIRCLE)

Last Visit Date ______________

Parent"s Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

3 Mother's Information ☐ Stepmother ☐ Guardian

Name ______________________

Work # ____________ Ext ______ Home # ____________

Employer ______________________

SS # ______________ DL # ______________

Father's Information ☐ Stepfather ☐ Guardian

Name ______________________

Work # ____________ Ext ______ Home # ____________

Employer ______________________

SS # ______________ DL # ______________

4 Person responsible for account

Name ______________ Relation ________

Billing Address ______________________

____
City State Zip

Employer ______________________

Work # ____________ Ext ______ Home # ____________

SS # ______________ DL # ______________

Who is responsible for making appointments?

Name ______________________

Work # ____________ Ext ______ Home # ____________

5 Primary Dental Insurance

Insurance Co. Name ______________________

Insurance Co. Address ______________________

Insurance Co. Phone ______________________

Group # (Plan, Local or Policy #) ______________________

Insured's Name ______________ Relation ________

Insured's Birthday ____/____/____ Insured's SS # ____________

Insured's Employer ______________________

Orthodontic coverage? ☐ Yes ☐ No

Secondary Dental Insurance

Insurance Co. Name ______________________

Insurance Co. Address ______________________

Insurance Co. Phone ______________________

Group # (Plan, Local or Policy #) ______________________

Insured's Name ______________ Relation ________

Insured's Birthday ____/____/____ Insured's SS # ____________

Insured's Employer ______________________

Orthodontic coverage? ☐ Yes ☐ No

Patient Name ____________________

MEDICAL HEALTH

Name and address of physician ____________________

Have you been under a physician's care during the past 2 years? __________ For ____________________

Have you been treated in a hospital in the past 2 years? __________ For ____________________

Have you ever had major surgery? ____________________

If female: Are you taking hormones or birth control? __________ Are you pregnant or nursing? __________

Have you had cankers or cold sores on your lips, tongue, gums or body? ____________________

Are you now taking or have you taken any prescription drugs during the past year? __________ For ____________________

____

Are you allergic to ( ) Penicillin ( ) Codeine ( ) Dental Anesthetics ( ) Tetracycline ( ) Latex ( ) Aspirin ( ) Erythromycin ( ) Other ____________________

Have you had or do you now have:

	Yes	No		Yes	No
AIDS / HIV+	( )	( )	Hepatitis	( )	( )
Abnormal blood pressure	( )	( )	Herpes	( )	( )
Allergies	( )	( )	Jaundice	( )	( )
Anemia	( )	( )	Kidney disease	( )	( )
Angina	( )	( )	Liver disease	( )	( )
Arthritis	( )	( )	Organ transplant	( )	( )
Artificial heart valves	( )	( )	Pacemaker	( )	( )
Artificial joints	( )	( )	Polio	( )	( )
Asthma	( )	( )	Prolonged bleeding	( )	( )
Cancer	( )	( )	Prolonged cough	( )	( )
Chemotherapy	( )	( )	Psychiatric treatment	( )	( )
Congenital heart lesions	( )	( )	Radiation therapy	( )	( )
Diabetes	( )	( )	Rheumatic fever	( )	( )
Drug dependency	( )	( )	Sickle cell anemia	( )	( )
Epilepsy	( )	( )	Stroke	( )	( )
Fainting	( )	( )	Thyroid disease	( )	( )
Glaucoma	( )	( )	Tuberculosis	( )	( )
Heart disease	( )	( )	Ulcers	( )	( )
Heart murmur	( )	( )	Venereal disease	( )	( )
Hearing impairment	( )	( )			

Have you any disease, condition, or problem not previously listed? ____________________

Date of last Dental X-Rays ____________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature ____________________ Date __________

CONSENT:
The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of Patient) ____________________ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 90 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient ____________________ Date __________ Witness ____________________

Parent or Responsible Party ____________________ Relationship to Patient ____________________