John P. Kenney, DDS Ltd. and Associates

Children's Dentistry in Park Ridge

WELCOME TO OUR PRACTICE

So that we may properly evaluate and treat your child, please take a few moments and carefully review and answer each of the questions on **BOTH PAGES OF THIS FORM**, Thank you.

Child's Name ______________________________ (Boy / Girl) Nickname ______________
Last First Middle Circle

Date of Birth ______________ Age ____ School ______________________ Grade ________

Child's Address ____

Child's Residence Phone #________________ Hobbies______________________

Father's Name ______________________ Mother's Name ______________________

Father's Date of Birth ______________________ Mother's Date of Birth ______________________

Father's SS#______________________ Mother's SS# ______________________

Father's Address______________________ Mother's Address ______________________

______________________ ______________________

How Long? ____________ How Long? ____________

Father's E-mail Address ______________________ Mother's E-mail Address______________________

Father's Residence Phone #______________________ Mother's Residence Phone # ______________________

Father's Cell Phone / Pager #______________________ Mother's Cell Phone / Pager # ______________________

Father's Occupation ______________________ Mother's Occupation ______________________

Father Employed by ______________________ Mother Employed by______________________

How Long? ____________ How Long? ____________

Parental Status: (Circle) Married Remarried Separated Divorced (Joint/Sole Custody) Widow(er) Single Step Parent Guardian

How did you hear about our office ---- Whom may we thank? ______________________________

Names and Ages of Other Children in Family ______________________________

DENTAL INSURANCE

Do you have Dental Insurance? Yes No

Primary Carrier (Dad/Mom) ______________________________ Group No. ______________

Secondary Carrier (Dad/Mom)______________________________ Group No. ______________

AS PAYMENT IS DUE AT THE TIME OF SERVICE AND *PAYMENT IN FULL IS DUE FOR THE INITIAL VISIT*, PLEASE INDICATE THE METHOD OF ROUTINE PAYMENT FOR YOUR ACCOUNT: (Circle)

Cash Check Visa MasterCard

DENTAL HISTORY

1. What prompted you to bring your child to our office today?______________________________
2. When did your child's first tooth erupt? (approximate age) __________ Similar Family History? Yes No
3. Do you desire complete dental services for you child? Yes No Explain ______________________
4. Name of last dentist? ______________________________
5. Date of last visit? ________________ For what services?______________________
6. Child's attitude towards dentistry and doctors in general ______________________
7. Any unhappy dental visits? Yes No If no, why?______________________
8. Has child complained about teeth? Yes No How long?______________________
9. Past injury to Mouth, Teeth, Head? Yes No Explain ______________________
10. Oral Habits: (Circle) Thumb/Finger Sucking Nail-Biting Mouth-Breathing Pacifier Nursing/Bottle How long? ______
11. Has child ever had a problem with: (Circle) Clinching/Grinding Teeth Swelling/Lumps in Mouth Blisters/Cold Sores Pain in or about Ears Bleeding Gums --- How long? ________ Explain ______________
12. How often does child brush? ____________ Does parent help with brushing? Yes No Is floss used? Yes No
13. Has child lived in a non-fluoridated area (including the prenatal period)? Yes No How long? ______________
14. Was child breast fed? Yes No How long? __________ Was child bottle fed? Yes No How long? __________

Health History

Child's Physician ______________________________ Phone #____________________ Date of Last Visit ___________

Address ____________________________________ Reason for Visit ______________________________________

Is child currently under treatment? Yes No If yes, why?____

Is child currently or in the last 60 days taking any medication(s)? Yes No If yes, why? ___________________________

Is or was child taking ***ANY*** daily medications, e.g., for sinus/ear infections, bladder infections, etc.? Yes No

What medication(s)?____

Does child bleed excessively when cut? Yes No

Has child ever been hospitalized? When?______________________ Why?__________________________________

Has child ever had surgery? When? _________________________ Why?__________________________________

Is child allergic to Penicillin, Local Anesthetics, (---Caines) or other drugs? _______________________________________

Other allergies? Food/Dyes Dust Pollen Animal? ____

Does child have good physical coordination? Yes No Any emotional problems? Yes No If no, explain ________________

HAS CHILD EVER HAD HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING?
ARE CHILDHOOD IMMUNIZATIONS UP-TO-DATE? (DPT/Polio, etc.) Yes No

_____ ADD/ADHD	_____Cerebral Palsy	_____Epilepsy	_____HIV/AIDS	_____Mumps
_____Anemia	_____Chicken Pox	_____Eye/Vision	_____Kidneys	_____Radiation Treament
_____Asthma	_____Chronic Sinus	_____Fainting	_____Learning Disability	_____Rheumatic Fever
_____Autism	_____Convulsions	_____Hearing	_____Malignancy	_____Sickle Cell
_____Bladder	_____Diabetes	_____Heart	_____Measles	_____Tuberculosis
_____Blood Transfusion	_____Ears/Ear Tubes	_____Hepatitis	_____Mononucleosis	_____Thyroid

Please describe any current or past family history, medical treatment, pending surgery, recent injuries or other information that the Doctor should be aware of that has not been covered on this form and may have an effect on the treatment or behavior of this child:

____

OFFICE POLICY / TREATMENT CONSENT

APPOINTMENTS: Each appointment represents a specific amount of time reserved for your child's dental treatment. WE realize that your time, like ours, is valuable and we endeavor to stay on time. Occasionally, due to patient emergencies we may run a bit behind. Remember that your child would get the same consideration and prompt attention. Please plan to arrive for future appointments no more than ***FIVE*** minutes earlier than scheduled, as your early arrival will affect other parent's schedules unfairly. Please provide us with 24 hours notice if for some URGENT reason your child is unable to keep their appointment. Appointment failures with less than 24 hours notice may incur a cancellation charge. Repeated cancellations will cause us to appoint your child at less desirable times.
INSURANCE: YOUR INSURANCE IS A CONTRACT BETWEEN ***YOU AND YOUR CARRIER*** SINCE EACH POLICY HAS DIFFERENT PROVISIONS AND LEVELS OF PAYMENT, AND IN ORDER TO KEEP OUR FEES REASONABLE, ***WE REQUIRE THAT PAYMENT IN FULL FOR ALL CHARGES AT THE INITIAL VISIT BE MADE AT THE TIME OF SERVICE. We will file your insurance and they will reimburse you directly. For subsequent visits with dental insurance that is in force. We require that the estimated co-payment be made at the time of service. WITHOUT DENTAL INSURANCE WE REQUIRE PAYMENT FOR ROUTINE SERVICES, e.g., (Initial Visits, Check-ups, Cleanings, Fillings, Sealants, Pulp Therapy and Extractions) BE MADE AT THE TIME THEY ARE RENDERED.*** For all ***non-routine*** services, we will be happy to work out a payment plan. For your convenience, we accept Visa & MasterCard.

CONSENT

I hereby certify that the foregoing information is correct and give my consent for treatment on the above named child. Furthermore, ***I WILL PERSONALLY BE RESPONSIBLE FOR ANY FINANCIAL OBLIGATIONS INCURRED ON THIS CHILD FOR TREATMENT.*** I understand that balances including pending insurance that are past due without prior financial arrangements may be turned over to a service bureau for collection.
I understand that in order to complete necessary dental treatment on my child certain BEHAVIOR MANAGEMENT TECHNIQUES generally accepted and used in pediatric dentistry may be necessary including the use of Voice Control, Passive Restraint, Mouth Props, Rubber Dam and/or Nitrous Oxide Analgesia. If you have any questions regarding use of these modalities, please feel free to ask the doctor. We are able to take a crying fearful child, treat them and then have them come out of the treatment area with a smile on their face. Parents will be allowed in the treatment area ***AT THE DOCTOR'S DISCRETION.*** We do this to give ***our undivided attention to your child and to have their complete attention as well.*** Thank you.

______________________________ ______________________________ ______________________________

Signature *Relationship* *Date*