

Welcome to Just for Kids Pediatric Dentistry. Health issues or certain medications the patient may be taking could have an important interrelationship with the dental care you will receive. The information provided on this form is important to your child's dental health and must be filled out by a parent or legal guardian. Please send completed form to [info@justforkidsnaperville.com](mailto:info@justforkidsnaperville.com), fax to 630-579-0850 Thank you!

**Patient Information**

Today's date: \_\_\_\_\_

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Preferred Name \_\_\_\_\_ Gender  Male  Female  MTF  FTM

Date of Last Dental Appointment \_\_\_\_\_ Dentist/Practice Name \_\_\_\_\_

What services did your child have with last Dentist? \_\_\_\_\_ X-Rays? Y/N When? \_\_\_\_\_

Any siblings to the patient that will be attending our practice? \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Is there anything you can tell us to help "Connect" with your child? (i.e.: favorite movie, princesses, trains, Spiderman, arts/crafts, family dog, etc.)

**Parent or Guardian Information**

Parents' Names \_\_\_\_\_  
\_\_\_\_\_

Marital status  M  D  Single  
 Separated  Domestic Partner

With Whom do children reside? \_\_\_\_\_ Primary language spoken at home? \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_

(alternate) Home address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_

Cell Phone(NAME)(Appt info sent) \_\_\_\_\_

Cell Phone (ALT/ NAME) \_\_\_\_\_

Email (Office & appt info sent) \_\_\_\_\_

**\*\*Parent or guardian must be at first visit\*\* Any follow-up appointments please let front desk know if anyone else is bringing patient\*\***

**SECONDARY ADULT CONSENT:(i.e.: grandma, nannie, caregiver) May accompany your child to future appointments AND give us consent to discuss treatment needs. \*let front desk know prior to visit\***

First/Last Name \_\_\_\_\_ Relationship to child(ren): \_\_\_\_\_

Home/Cell phone \_\_\_\_\_ Discuss Treatment **Y/N**

Parent Signature for Secondary Adult: \_\_\_\_\_

## **DENTAL HISTORY**

Primary reason for today's visit? \_\_\_\_\_

Has your child ever been to the dentist? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_ If Yes, Date of last visit? \_\_\_\_\_

If yes, how was your child's past dental experience? **Positive/Negative** Comments \_\_\_\_\_

Is there a family history of cavities? **Y/N** \_\_\_\_\_ Family history of missing or extra teeth? **Y/N** \_\_\_\_\_

How often does the patient brush? \_\_\_\_\_ Floss? \_\_\_\_\_ Do you assist? \_\_\_\_\_

What kind of toothpaste does your child use?  With fluoride  Without fluoride  I am not sure

Primary source of drinking water at home?  City/community supply  Well water  Bottled water  Reverse osmosis filter

Does your child eat three meals a day? **YES/NO** \_\_\_\_\_ Is your child on a special or restrictive diet? **YES/NO** \_\_\_\_\_

If Yes, please describe \_\_\_\_\_

Does your child have a diet high in sugar and/or starches? **YES/NO** \_\_\_\_\_ Is your child a "picky eater"? **YES/NO** \_\_\_\_\_

### **How often does your child have any of the following?**

Candy and/or other sweets?  Rarely  Occasionally  1-2 times per day  >2 times per day

Snacks between meals  Rarely  Occasionally  1-2 times per day  >2 times per day

Soft drinks, sodas, juices, teas, or energy drinks  Rarely  Occasionally  1-2 times per day  >2 times per day

Please list child's most frequent snacks: \_\_\_\_\_

Has your child ever had orthodontic treatment (braces)? **YES/NO** \_\_\_\_\_ **Orthodontist Name/facility** \_\_\_\_\_

Has your child ever experienced an adverse reaction during, or in conjunction with a medical or dental procedure?

**YES** \_\_\_\_\_ **NO** \_\_\_\_\_ Please explain \_\_\_\_\_

**Circle EACH Y or N** Has your child had or have any of the following:

**Y/N** Wear a mouthguard **Y/N** Snoring/Mouth breathing **Y/N** Trouble chewing or swallowing

**Y/N** Bad Breath **Y/N** Sensitivity to hot/cold **Y/N** Loose teeth or broken fillings

**Y/N** Bleeding gums **Y/N** Sensitivity when biting **Y/N** Food collection between teeth

**Y/N** Sensitivity to sweets **Y/N** Fluoride supplements **Y/N** Mouth Sores/Fever Blisters

**Y/N** Jaw joint problems (clicking, popping, locking or pain?) **Y/N** Bump or trauma to teeth

**Y/N** Oral habits:  Thumb/finger sucking  pacifier  Nail biting  Other \_\_\_\_\_

If Yes, for how long & is the habit still present? \_\_\_\_\_

**Is there anything else you would like us to know before treating your child? Please explain:**

## **MEDICAL HISTORY**

Name of **child's physician** \_\_\_\_\_ Phone \_\_\_\_\_

**Child's Immunizations up to date?** **Y/N** \_\_\_\_\_

Is your child presently under medical care? **Y/N** Please Explain: \_\_\_\_\_

Does your child see a Specialist? **Y/N** Please explain: \_\_\_\_\_

If Yes, name & phone of **Medical Specialist:** \_\_\_\_\_

**Surgeries? Hospitalized? Surgical procedures? Put to sleep/Under general anesthesia? Sedation?** **Y/N** \_\_\_\_\_

**If yes, please list procedures and dates:**

**ALLERGIES:** Is your child allergic to any of the following? Circle any/all that apply:

**Antibiotics Gluten Seasonal Acrylics Food Dye Metals Sulfa Anesthetics Latex Dairy Peanuts/tree nuts**

OTHER? Please list:

**PLEASE CIRCLE Y or N** if your child has been diagnosed with or treated for any of the following:

- |                              |   |                                      |  |
|------------------------------|---|--------------------------------------|--|
| <b>Y/N</b> ADHD/ADD          | <b>Y/N</b> Cleft lip/Palate                         | <b>Y/N</b> Eating disorders          | <b>Y/N</b> Anxiety/Depression (circle one) |
| <b>Y/N</b> Down Syndrome     | <b>Y/N</b> Cognitive delays                         | <b>Y/N</b> Blood Transfusion         | <b>Y/N</b> Bleeding Disorder               |
| <b>Y/N</b> Skin Problems     | <b>Y/N</b> Cerebral Palsy (CP)                      | <b>Y/N</b> Diabetes Type I/II        | <b>Y/N</b> Cystic Fibrosis                 |
| <b>Y/N</b> Acid reflux/GERD  | <b>Y/N</b> Frequent Nose Bleeds                     | <b>Y/N</b> Autism Spectrum Disorder  | <b>Y/N</b> Cancers/Tumors                  |
| <b>Y/N</b> Seizures/Epilepsy | <b>Y/N</b> Bone Issues                              | <b>Y/N</b> Asthma/Breathing problems | <b>Y/N</b> Anemia                          |
| <b>Y/N</b> Impaired Speech   | <b>Y/N</b> Early onset of puberty/hormonal problems | <b>Y/N</b> Sickle cell disease/Trait | <b>Y/N</b> Cold Sores/ Herpes              |
| <b>Y/N</b> Impaired vision   | <b>Y/N</b> Headaches/Dizziness                      | <b>Y/N</b> Celiac disease            |  |
| <b>Y/N</b> Impaired Hearing  |   |                                      |  |
- Y/N** Infectious diseases: Mono, Hepatitis A-E, Tuberculosis, scarlet fever, Cytomegalovirus (CMV), MRSA, STDs, or HIV/AIDS
- Y/N** Congenital Heart defect/disease, **Y/N** Rheumatic fever or rheumatic heart disease
- Y/N** Heart murmur (EVER?)
- Y/N** Neurological, developmental or sensory disorders \_\_\_\_\_

**If yes to ANY, please explain:**

**Social/Cognitive Development:**  at age level  1-2 years behind  More than 2 years behind

Any issues with physical **growth and/or development?** **YES/NO**

**If yes to ANY, please explain:**

**Any inherited medical conditions, complications before or during birth, prematurity, birth defects or syndromes not previously noted on this form? YES/NO** If yes, please provide details: \_\_\_\_\_

**Behavioral, emotional, or psychiatric diagnoses/treatment? YES/NO** If Yes, please list:

**PLEASE LIST ALL MEDICATIONS OTC AND/OR PRESCRIBED PATIENT IS CURRENTLY TAKING. (ALLERGY, INHALER, ETC, ALL ARE IMPORTANT)**

**Medication/Reason/Dosage:**

I understand the information given is correct to the best of my knowledge and it is my responsibility to inform JFK of any changes in my child's medical condition or medications.

**SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

# EXAM CONSENT

## OFFICE VISITS

All children 3 years of age and above will be brought back to visit with the dentist by themselves. Only for extremely young patients or for patients with special needs will an exception be made to this policy. **A parent or legal guardian MUST be present for all appointments.**

## X-Rays & Examination

I understand that my child will be receiving a dental examination from a state licensed and board-certified pediatric dentist. The initial visit is spent conducting a comprehensive examination & depending on your child’s age, several x-rays will be taken to determine the presence of cavities between the teeth and the number and location of permanent teeth. **The doctors assess cavity risk and recommend x-rays based on what is best for our patients, regardless of whether your insurance covers this or not.**

## Dental Cleaning & Fluoride Treatment

I authorize the providers at Just for Kids Pediatric Dentistry to clean and apply fluoride to my child’s teeth. I understand that the application of fluoride is part of the standard of care for children and helps prevent cavities. I understand **recommendations are based on what is standard of care and not based on what your insurance will or will not cover.**

## Recall/Routine Re-care system

Recall (6 month) examinations will be conducted in a similar manner. However, if your child maintains zero cavity growth for 12-18 months, we will recommend that diagnostic x-rays be taken on an annual basis rather than at each six-month recall appointment. **IT IS IMPERATIVE THAT ALL CHANGES TO YOUR CHILD’S MEDICAL HISTORY BE BROUGHT TO OUR ATTENTION BEFORE YOUR CHILD IS TAKEN BACK TO SEE THE DENTIST.**

## Dental Services

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia and routine dental treatment with use of proper and acceptable methods to complete treatment. I accept responsibility for payment of services rendered for my child. I understand I will be informed of any treatment other than routine dental treatment before it is performed. **It is the Parent’s responsibility to inform the staff during treatment planning if you wish to decline recommended treatment.**

## Photography Consent

Digital photos are automatically taken of child(ren) to be used exclusively within their dental record for purposes of ID and dental treatment.

I consent to having occasional “candid” photos and videos taken of my child(ren) and displayed in the office, or social media, such as Instagram and Facebook to promote great dental visits and education. Also, can email to parent upon request:)

I consent  I do not consent

## Financial Policy & Insurance

Payment for initial visit is due at the time of service. **We are out of network with all insurance companies.** Payment for all visits is due at time of service unless prior arrangements have been made. Insurance is a contract between you and your insurance company; therefore, we ask that you keep up to date with outstanding claims etc. **If your insurance company does not make payments to out-of-network provider, payment is due at the time of services. If you do NOT have dental insurance, payment is due at time of service.** If there are restorative charges, we will require co-pay, plus deductible. Any balance automatically becomes your responsibility and must be paid in full within 14 days after 1<sup>st</sup> statement is sent.

**ANY INSURANCE CHANGES, PLEASE LET US KNOW UPON CHECK IN.**

\*Please ask our team about CARE CREDIT as a payment option.

INITIAL \_\_\_\_\_

**MISSED APPOINTMENTS:** You must provide at least 24 hours’ notice if you cancel/miss your schedule appointment. Otherwise, we reserve the right to charge an amount of **\$75.00** for a broken appointment. If two appointments are missed during peak, non-school hours, we reserve the right to schedule appointments for your child only during non-peak hours. We also reserve the right to dismiss you from our practice for multiple missed appointments.

INITIAL \_\_\_\_\_

## MONTHLY BILLING CHARGE:

If any portion of your account remains unpaid, a monthly billing charge of \$1.50 per month will be added to the account after 30 days **with no exceptions.**

**OTHER CHARGES (Subject to change without notice)** Duplication of Records: \$15.00 per child Returned Check: \$35.00

**Authorization and Release** I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the periods of such dental care to third party payors, health practitioners or as required by law. **Initial** \_\_\_\_\_

**Parent’s Signature & relationship to child:** \_\_\_\_\_ **Date:** \_\_\_\_\_