Waco Kids Dental
1121 Lake Air Drive
Waco, TX 76710
P: 254-772-8330
F: 254-772-8496

Information Sheet

Today's Date: _____

Patient's Name : _____
FIRST MI LAST

Date of Birth: _____Age:_____ Male or Female

Home Phone: (___) _____ Cell Phone: (___) _____

Address: _____City:_____ Zip:_____

Email: _____ **TEXT or EMAIL confirmation?**

Patient's Medicaid (please circle) MCNA/CHIPS, DENTAQUEST/CHIPS, TRADITIONAL ID #_____

Childs School or Daycare that they attend: _____

Other siblings that seen in the office: _____

Who is accompanying the child today?

Name:_____ Relation:_____

Child resides with (circle one) Both Parents, Mother, Father, or Other (LIST) _____

Father or Guardian's Information: *(please circle)* Father, Stepfather, Guardian

Name: _____ Date of Birth:_____

Phone# (___) _____SS#_____DL#_____

Email:_____ Employer: _____

Insurance Information

Insurance Name:_____Insurance Phone#_____

Group#_____ID# _____

Mom or Guardian's Information: *(please circle)* Mother, Stepmother, Guardian

Name:_____Date of Birth: _____

Phone# (___)_____SS#_____DL#_____

Email:_____Employer:_____

Insurance Information

Insurance Name:_____Insurance Phone#_____

Group#_____ID#_____

Relative or Friend not living with you: *(Please list someone)*

Name: _____ Relationship to patient: _____

Phone :(___) _____

Whom may we thank for referring you? _____

Previous/Present Dentist:_____Last Visit:_____

~Serving the Children of Central Texas~

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Why did you bring your child to the dentist today_____

Is the child currently in pain? **YES** or **NO**
Does the child require antibiotics before dental treatment? **YES** or **NO**
Has the child ever had a serious/difficult problem with any dental work? **YES** or **NO**
Child's Medical Doctor:_____Phone#_____
List any Medications that the child is currently taking:_____
_____

List any drugs/things that the child is allergic to: _____

(Please circle if this applies) LATEX, METALS, PLASTIC, OR RED DYE

Has the child experienced the following medical problems?

ADD/ADHD	**Y or N**
Any Hospital Stays/Operations?	**Y or N**
Artificial Bones/ Joints/ Valve	**Y or N**
Asthma	**Y or N**
Cancer	**Y or N**
Congenital Heart Defect	**Y or N**
Convulsions	**Y or N**
Diabetes	**Y or N**
Epilepsy	**Y or N**
Handicaps/ Disabilities/ ASD	**Y or N**
Hearing Impairment	**Y or N**
Heart Murmur	**Y or N**
High Blood Pressure	**Y or N**
Hives	**Y or N**
Kidney/ Liver Problems	**Y or N**
Mitral Valve Prolapse	**Y or N**
Sickle Cell Disease/ Traits	**Y or N**
Rheumatic Fever	**Y or N**
Tuberculosis	**Y or N**

Does/did the child experience any of the following?

Chewing on Objects	**Y or N**
Grinding Teeth	**Y or N**
Lip Sucking/ Biting	**Y or N**
Mouth Breather	**Y or N**
Nail Biting	**Y or N**
Nursing Bottle Habits	**Y or N**
Speech Problems	**Y or N**
Thumb/ Finger Sucking	**Y or N**
Used Pacifier	**Y or N**

Please discuss any serious medical problems that the child has:_____
_____

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control by OSHA, the CDC and the ADA.

I affirm that the information I have provided is to the best of my knowledge. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian _____ DATE:_____