KIDZ DENTISTRY
Ryan Bybee, DDS
Helping Smiles Grow

★ Tell Us About Your Child ★

Child's Name: _____ Birthdate: _____ Age: _____ ☐ Boy ☐ Girl
Favorite Toys / TV: _____
How did you hear about us? _____

Parent's Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Remarried ☐ Single ☐ Partnered

	Mother	**Father**
Name		
Phone – Home		
– Cell		
– Work		
Home address, city, zip		
Date of Birth		
Email		
Employer		
Position		
Business address, city, zip		
Social Security Number		
Driver's License Number		

Insurance Information

	Mother	**Father**
Insurance Name		
Employer Name		
Insurance Address / Phone		
ID #		
Group #		
Relation to patient		

Authorization and Release

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

_____

Signature Date

TODAY'S DATE: _____

Medical History

Child's Name: _____
Child's Pediatrician: _____
Practice Name: _____
Specialty Doctor Name: _____

Does your child have now or has had any of the following:	Y	N
Is your child in good health?		
Allergies to anything?		
Asthma or breathing disorders?		
Birth complications?		
Family history of bleeding disorders?		
Heart murmur or heart disease?		
Taking any medications? Please list:		
Hospitalizations?		
Surgeries performed?		
Seizures?		
Shunts, pins, rods or screws placed?		
Has your child ever been advised by a physician to take antibiotics before dental procedures?		
Other:		

Has your child had a history of any of the following?

- ☐ AIDS
- ☐ Anemia
- ☐ Asthma
- ☐ ADD / ADHD
- ☐ Autism
- ☐ Blood transfusions
- ☐ Blood disorders / bruise easily
- ☐ Cancer / tumors
- ☐ Cerebral Palsy
- ☐ Cleft Lip / Palate
- ☐ Congenital birth defects
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI disease
- ☐ Headaches
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mental / Speech delays
- ☐ Mumps/Measles / Chickenpox
- ☐ Personality / Social disorder
- ☐ Physical delays
- ☐ Rheumatic fever
- ☐ Seizures / convulsions
- ☐ Sinus problems
- ☐ Thyroid
- ☐ Tuberculosis

DOCTOR NOTES

Dental History

Is your child currently in pain? ☐ Yes ☐ No
Has your child ever been to a dentist? ☐ Yes ☐ No
Last exam date:
Last x-rays date:
Last cleaning date:
Reason for visit today: _____

Previous dentist's name:
Were you satisfied with the prior dentist? ☐ Yes ☐ No
Explain: _____
Any negative dental experiences? ☐ Yes ☐ No
Explain: _____

Are you aware of any cavities now? ☐ Yes ☐ No
Does your child brush daily? ☐ Yes ☐ No
Does your child floss? ☐ Yes ☐ No
Is your child breast or bottle feeding? ☐ Yes ☐ No
At what age did they stop? _____
Does your child bite cheeks, lips or nails? ☐ Yes ☐ No
Does your child suck their thumb? ☐ Yes ☐ No

If your child needs dental work, how do you anticipate their behavior to be?
☐ Perfect/cooperative ☐ Shy/needs TLC ☐ Will cry
☐ Nervous ☐ Combative/uncooperative

If your child has cavities, which do you feel would be best?

☐ **Nitrous Oxide (laughing gas)**
** For well-behaved children with minimal anxiety

☐ **In-office Oral Sedation (child awake)**
** For moderate dental needs when child has moderate to high anxiety

☐ **Surgery Center / General Anesthesia (child asleep)**
** For severe anxiety, uncooperative children, young children, children with complex and extensive dental needs, children that are too high risk to sedate in office

☐ **"Hold and Go"**
I do not want medication for my child and I wish for you to hold my child down even if they cry. I understand that there will be a behavior management fee charged.