™ WELCOME ™

KEVIN J. REECE, D.D.S.
Family Dentistry

97 South Professional South
Payson, Utah 84651
(801)465-4474

Tell Us About Your Child

Today's Date:_____

Child's Name:_____

Nickname:_____ ☐ Male ☐ Female

Child's Birthdate:____/____/_____Child's Age:_____

School:_____Grade:_____

Home No:_____Cell_____

Home Address:_____
Apt/Condo#

_____
City State Zip Code

Email _____

Who is accompanying the child today?

Name:_____Relation_____

Do You have legal custody of this child ☐ Yes ☐ No

Whom may we Thank for referring you?_____

Other family members seen by us:_____

_____

Previous/Present Dentist:_____

Last Visit Date:_____

Parent's Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

Mother's Information: (☐Step Mother ☐ Guardian)

Name:_____
Work No:_____Ext:____Home No:_____
Employer:_____

Father's Information: (☐ Step Father ☐ Guardian)

Name:_____
Work No;_____Ext:_____Home No:_____
Employer:_____

Person Responsible for account

Name:_____

Relationship:_____

Billing Address:_____

_____

Work No:_____Ext:_____Home No:_____

Employer:_____

Name:_____

Work No:_____Ext:____Home No:_____

Primary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone No:_____

Group #_____ID#_____

Insured's Name:_____

Relationship:_____

Insured's Birthday:___/___/___

Insured's Employer:_____

SECONDARY DENTAL INSURANCE

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone No:_____

Group # _____ID#_____

Insured's Name:_____

Relationship:_____

Insured's Birthday:____/____/____

Insured's Employer:_____

CONTINUED ON BACK OF FORM

Why did you bring the child to the Dentist today?_____

_____

Has the child ever had a serious/difficult problem associated with Previous dental work? ☐ No ☐ Yes

Is the child's water fluoridated? ☐ No ☐ Yes

Do you now or have you ever experienced pain/discomfort in Your jaw joint (TMJ/TMD? ☐ No ☐ Yes

Does the child brush their teeth daily? ☐ No ☐ Yes

Floss their teeth daily? ☐ No ☐ Yes

Child's Physician:_____

Phone No:_____Date of last visit:_____

Is the child currently under the care of a physician? ☐ No ☐ Yes

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:_____
_____

Please list all drugs that the child is allergic to:_____
_____

Has the child ever had any of the following medical problems?

Y N Heart Murmur	Y N Congenital Heart Defect
Y N Cancer	Y N Convulsions/Epilepsy
Y N Diabetes	Y N Abnormal Bleeding
Y N Rheumatic Fever	Y N Hearing Impairment
Y N HIV+/AIDS	Y N Any Operations
Y N Hemophilia	Y N Any stays in a Hospital
Y N Asthma	Y N Kidney/Liver Problems
Y N Hepatitis	Y N Handicaps/Disabilities
Y N Tuberculosis (TB)	Y N Allergies to any drugs

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

Does the child have any of the following habits?

Y N Thumb/Finger Sucking
Y N Lip Sucking/Biting
Y N Nail Biting
Y N Nursing Bottle Habits

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

I understand that the information that I have given is correct to the best of my knowledge, that I will be held in the strictest of confidence, and 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 dental services my child may need.

_____
Signature of parent or guardian

OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical/dental information with the parent/guardian And patient named herein. Initials_____Date_____

Doctor's Comments:_____
_____

MEDICAL HISTORY UPDATE

1. Date_____Comments_____Signature_____
2. Date_____Comments_____Signature_____