Waco Kids Dental
1121 Lake Air Drive
Waco, TX 76710
P: 254-772-8330
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Aaron C. Blackwelder DDS
Board Certified Pediatric Dental Specialist
Mark C. Coons, DDS
Board Certified Pediatric Dental Specialist
Tjel C. Olson DMD
General Dentistry Limited to Children

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:_____

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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 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	**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:_____