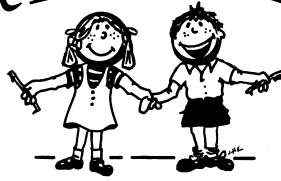


Pediatric Dentistry



Richard W. Kennedy, D.M.D.

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508 S. Locust St.
Oxford, OH 45056
☎ (513) 523-8289

CHILD'S NAME _____ BIRTH DATE _____ SEX _____ AGE _____

FATHER'S NAME _____ BIRTH DATE _____ SS# _____

FATHER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

FATHER'S EMPLOYER _____ HOME PHONE _____

CELL PHONE _____ WORK PHONE _____

EMAIL ADDRESS _____

MOTHER'S NAME _____ BIRTH DATE _____ S.S. # _____

MOTHER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

MOTHER'S EMPLOYER _____ HOME PHONE _____

CELL PHONE _____ WORK PHONE _____

EMAIL ADDRESS _____

CHILD'S MEDICAL DOCTOR _____ LAST VISIT _____

REASON _____

NAME OF PRIMARY DENTAL INSURANCE _____ NAME OF SECONDARY DENTAL INSURANCE _____

NAME OF INSURED _____ NAME OF INSURED _____

INS. I.D. # _____ INS. I.D. # _____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

HOW DID YOU LEARN ABOUT THIS OFFICE? _____

.....

PLEASE READ CAREFULLY:

BECAUSE YOUR CHILD IS A MINOR, IT BECOMES NECESSARY THAT A SIGNED PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY/AND ALL NECESSARY DENTAL SERVICES CAN BE STARTED AND ACCOMPLISHED BY DR. KENNEDY.

AUTHORIZATION IS HEREBY GRANTED AS SUCH. FURTHERMORE, I WILL BE RESPONSIBLE FOR ANY FEE CHARGED FOR THIS DENTAL AGREEMENT. I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO DENTAL CLAIMS TO MY INSURANCE COMPANY.

**** NOTE: OUR OFFICE POLICY IS THAT ALL ACCOUNTS **
WILL BE BILLED TO THE PARENT
AUTHORIZING DENTAL TREATMENT**

Signature _____ Relationship _____ Date _____

PLEASE TURN OVER

MEDICAL INFORMATION

Please read and answer EACH question. Please check (✓) if your child has had any problem or history of the following. If you need assistance, we will be glad to help you.

	YES	NO
1. Abnormal bleeding problems	_____	_____
2. AIDS or AIDS related complex	_____	_____
3. Allergies	_____	_____
a) To local anesthetic	_____	_____
b) To any medications (drugs)	_____	_____
c) Latex	_____	_____
d) Other	_____	_____
4. Anemia	_____	_____
5. Arthritis	_____	_____
6. Asthma	_____	_____
7. Autism Spectrum	_____	_____
8. Bladder	_____	_____
9. Cerebral palsy	_____	_____
10. Convulsions or seizures	_____	_____
11. Cystic Fibrosis	_____	_____
12. Diabetes	_____	_____
13. Emotional problems	_____	_____
14. Fainting	_____	_____
15. Hearing problems	_____	_____
16. Heart murmur	_____	_____
17. Heart problems	_____	_____
18. Hepatitis	_____	_____
19. Hyperactivity or ADHD	_____	_____
20. Kidney disorders	_____	_____
21. Learning disabilities	_____	_____
22. Liver disorders	_____	_____
23. Malignancy or leukemia	_____	_____
24. Pregnancy	_____	_____
25. Radiation therapy	_____	_____
26. Special needs	_____ Physical	_____ Mental
27. Tuberculosis	_____	_____
28. Vomiting or GERD	_____	_____

If any of the above are checked "YES", please give a brief explanation: _____

Is your child presently taking any medications? _____ If so, what and prescribed by whom? _____

Has your child ever taken penicillin or amoxicillin? _____ Any allergic reactions? _____

Has your child ever been hospitalized? _____ If so, for what reason? _____

Has your child ever received any transfusions of blood, blood products or blood elements? _____

Does your child have any medical problems not listed above? _____

DENTAL INFORMATION

Last visit to a Dentist _____

Current dental problem? _____

Any unhappy dental visits? _____

Any injuries to the mouth, teeth, or head? _____

Any mouth habits (thumb-sucking, etc.)? _____