Thomas G. Wilson, D.D.S.
PEDIATRIC DENTIST/ ORTHODONTIST
Denise N. Evans, D.D.S.
PEDIATRIC DENTIST
Austin P. Foster D.D.S.
ORTHODONTIST

www.dmkidsdds.com ***515-278-2333***

Date ____________

Patient Information

Last Name ____________ First Name ____________ Middle Initial ____ Sex ____

Prefers to be Addressed By ____________ Date of Birth ____/____/____ Age (years) ____

Address ____________ Apt # ____

City ____________ State ____ Zip ____ Preferred Contact Phone ____________

Other family members treated at this office ____________

Parental Information

Circle One: Mother, Stepmother, Guardian

Name ____________

Date of Birth ____________

Social Security # ____________

E-mail Address ____________

Cell Phone ____________

Does Patient Live With You? ____________

Employer ____________

Employer Address ____________

Work Phone ____________

Complete if DIFFERENT from patient's home information:

Home Address ____________

City ____________ State ____ Zip ____

Home Telephone ____________

Circle One: Father, Stepfather, Guardian

Name ____________

Date of Birth ____________

Social Security # ____________

E-mail Address ____________

Cell Phone ____________

Does Patient Live With You? ____________

Employer ____________

Employer Address ____________

Work Phone ____________

Complete if DIFFERENT from patient's home information:

Home Address ____________

City ____________ State ____ Zip ____

Home Telephone ____________

Dental Insurance Information

(Please provide your insurance card to the receptionist)

Primary Insurance

Company ____________

Address ____________

City ____________ State ____ Zip ____

Insurance Telephone ____________

ID # ____________

Policy Holder's Name ____________

Relationship to Patient ____________

Secondary Insurance

Company ____________

Address ____________

City ____________ State ____ Zip ____

Insurance Telephone ____________

ID # ____________

Policy Holder's Name ____________

Relationship to Patient ____________

Please keep in mind that you are ultimately responsible for payment on your account. If your insurance does not pay the claim, you are responsible for the outstanding balance. Insurance is a contract between *you and the insurance company, not our office.*

DENTAL HISTORY

1. Previous dentist (if any) ____________ Date of last dental exam ____________
2. When, if ever, were x-rays taken? ____________
3. Has your child had any unfavorable dental experiences? ____________
4. Has your child been treated with Nitrous Oxide? (laughing gas) ____________ Lidocaine? (local anesthetic) ____________
5. Current Mouth Habits (Please Check): ☐ Thumb sucking ☐ Pacifier ☐ Mouth breathing ☐ Finger habit ☐ Tooth grinding ☐ Other ____________
6. How often does your child brush? ____________ Floss? ____________
7. Is there parental supervision? ____________ Brushing? ____________ Flossing? ____________
8. Does your child drink fluoridated water? ____________
9. Does your child use any fluoridated supplements? (rinses, vitamins)? ____________
10. Is your child still nursing? ____________ Taking a bottle? ____________
11. Does your child have a specific dental problem that needs to be addressed? ____________
    If so, explain ____________
12. Has your child had trauma to the mouth/teeth?
    If so, explain ____________

MEDICAL HISTORY

1. Is your child's general health good at this time? ☐ Yes ☐ No
2. Name of physician? ____________ Date of last physical: ____________
3. Is your child under the care of a physician at this time? ☐ Yes ☐ No
   If yes, explain: ____________
4. Is your child taking any medication? ☐ Yes ☐ No
   If yes, Medicine & reason for: ____________
5. Is your child allergic to any medication? (Penicillin, Sulfa, etc.) ☐ Yes ☐ No
   If yes, what: ____________
6. Does your child have any allergies? (metals or seasonal) ☐ Yes ☐ No
   If yes, what: ____________
7. Does your child have any food allergies? ____________
8. Has your child had tonsils and adenoids removed? ☐ Yes ☐ No Date: ____________
9. Has your child ever had a serious illness or been hospitalized? ☐ Yes ☐ No Date: ____________
   If yes, explain: ____________
10. Has your child ever been advised by their physician to take on antibiotic prior to any dental treatment? ☐ Yes ☐ No
    If yes, Antibiotic name & dose: ____________

Please Check all conditions your child has now or has had previously

______ Carries rescue inhaler	______ Carries epi pen for allergy	______ Speech Impairment
______ Heart condition, if yes, specify	______ Kidney problems	______ Sinusitis
______ Hepatitis (type ______)	______ Liver disease	______ Headaches/migraines
______ Has insulin pump	______ AIDS or H.I.V. positive	______ Cleft palate/lip
______ Diabetes	______ Prosthetic (artificial) joint	______ Spina bifida
______ Tuberculosis	______ Radiation therapy (cancer)	______ Scoliosis
______ Blood disorders/bleeding problems	______ Autistic	______ Latex allergy
______ Sickle cell	______ Mentally handicapped	______ Emotional anxiety
______ Asthma	______ ADD/ADHD	______ Other ______
______ Epilepsy (seizures)	______ Gluten intolerance/celiac disease	______

I certify that the information given is correct and give consent to treat my child.

Signature: ____________ Date ____________

(Please Circle One) *PARENT* *GUARDIAN* *OTHER*

Reviewed by ____________ Date ____________