# Welcome!

**Kurt E. Schabes, D.D.S. (616) 676-2223**

## Tell Us About Your Child

Today's Date: ______ Child's Home Phone #: (____)______ Social Security #: ______

Child's Name: ______ (Last, First, MI) Child's Birthdate: ___/___/___ Child's Age: ______

Nickname: ______ ❑ Male ❑ Female School: ______ Grade: ______

Child's Home Address: ______ (Street, City, State, Zip)

Whom may we thank for referring you? ______

## Parent's Information

Parent's Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Remarried ❑ Single

**Mother** Birthdate: ___/___/___ Home Phone #: (____)______ Work Phone #: (____)______

Name: ______ Social Security #: ______ Driver's License #: ______

Address: ______ (Street, City, State, Zip)

Employer: ______ Length of Employment: ______

**Father** Birthdate: ___/___/___ Home Phone #: (____)______ Work Phone #: (____)______

Name: ______ Social Security #: ______ Driver's License #: ______

Address: ______ (Street, City, State, Zip)

Employer: ______ Length of Employment: ______

## Insurance Information

**Primary Insurance** Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: ______ Phone #: (____)______ Group # (Plan, Local, or Policy #): ______

Insurance Co. Address: ______ (PO Box/Street, City, State, Zip)

Insured's Name: ______ Relationship to Patient: ______

Insured's Birthdate: ___/___/___ Social Security #: ______ Insured's Employer: ______

Employer's Address: ______ (Street, City, State, Zip)

**Secondary Insurance** Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: ______ Phone #: (____)______ Group # (Plan, Local, or Policy #): ______

Insurance Co. Address: ______ (PO Box/Street, City, State, Zip)

Insured's Name: ______ Relationship to Patient: ______

Insured's Birthdate: ___/___/___ Social Security #: ______ Insured's Employer: ______

Employer's Address: ______ (Street, City, State, Zip)

**CONTINUED ON BACK**

## Dental History

**Is the child currently in pain?** ❑ Yes ❑ No **What is the primary reason for today's visit?** ______

Has the child experienced problems with previous dental work? ❑ Yes ❑ No

Does the child brush his / her teeth daily? ❑ Yes ❑ No

Floss his / her teeth daily? ❑ Yes ❑ No

Previous / Present Dentist: ______ Date of Last Visit: ______
(Please Circle)

Has the child had Orthodonticl treatment? ❑ Yes ❑ No

Name of Orthodontist: ______

Are the child's teeth sensitive to pressure? ❑ Yes ❑ No Cold? ❑ Yes ❑ No Hot? ❑ Yes ❑ No

Does the child catch food between his/her teeth? ❑ Yes ❑ No Chew gum? ❑ Yes ❑ No

Child's favorite toothpaste: ______

Does your child use a soft toothbrush? ❑ Yes ❑ No

**Does / did the child have any of the following habits?**

❑ Lip Sucking / Biting
❑ Nail Biting
❑ Chewing on Objects
❑ Clenching / Grinding Teeth
❑ Thumb / Finger Sucking
❑ Nursing Bottle Habits
❑ Tongue / Cheek Biting
❑ Used Pacifier
❑ Tongue Thrust
❑ Mouth Breather
❑ Speech Problems
❑ Breast Fed

## Medical History

Child's Physician: ______ Phone #: (____)______ Date of last visit: ______

Address: ______
Street City State Zip

Is the child currently under the care of a physician? ❑ Yes ❑ No Please explain: ______

**Please describe the child's current physical health:** ❑ Good ❑ Fair ❑ Poor **Are Immunizations Current?** ❑ Yes ❑ No

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

Please list all drugs and/or things that cause the child allergic reactions: ______

Anything you would like to discuss with the Doctor in private? ❑ Yes ❑ No

**Has the child had/experienced any of the following:**

❑ Abnormal Bleeding
❑ AIDS / HIV+
❑ Allergies
❑ Anemia
❑ Any Hospital Stays / Operations
❑ Asthma
❑ Blood Transfusion
❑ Cancer
❑ Chicken Pox
❑ Congenital Heart Defect
❑ Convulsions
❑ Diabetes
❑ Epilepsy
❑ Handicaps / Disabilities
❑ Hearing Impairment
❑ Heart Murmur
❑ Hemophilia
❑ Hepatitis
❑ High Blood Pressure
❑ Hives
❑ Kidney Problems
❑ Liver Problems
❑ Low Blood Pressure
❑ Lupus
❑ Measles
❑ Mitral Valve Prolapse
❑ Mononucleosis
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Sickle Cell Anemia
❑ Skin Rash
❑ Tonsillitis
❑ Tuberculosis (TB)
❑ Use of Inhaler

**Please discuss any serious medical problems the child experiences/ed:** ______

______

## Authorization

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 including photographs needed for diagnostic and/or educational purposes. 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

My method of payment for services rendered for my child will be: ❑ Cash ❑ Check ❑ Credit Card

FORM #CH-SCHABES-02

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