

Welcome & Thank You for Choosing Us!

Date:

Celeste Wegrzyn, D.M.D., MS www.just4kidzdentistry.com

Phone #: _____

Child's Name:		Nickname:	Nickname:		
Gender: Male _	Female	Date of Birth	1:Ag	je:	
Your Child					
School	Gro	ade 5	SS#		
Child's Address:		City	State	Zip	
Who is accompanying child today?		 	Relationship	 	
Whom may we thank for referring you	to our office?				
Name and ages of other children in fam	ily				
Who is responsible for making appointm	nents?		Relationship		
Parent or Guardian Information:	Mother Stepmother	r Father :	Stepfather Guard	an	
Name	Address				
Email					
Employer					
Marital Status: Single Ma				75.3	
Parent or Guardian Information:			Stenfather Guard	an	
Name					
Email					
Employer					
Marital Status: Single Ma			UL#		
-	·	cea Widowed			
Preferred means of communicatio					
You may contact me at my hor	ne telephone number		//		
You may contact me on my mo	bile telephone number			- //	
You may contact me on my wo	rk telephone number			//	
You may send me an email at:					
Other					
Primary Insurance					
Insured's Name			Relationship		
Birthdate Employer			— Occupation		
Insurance Co.					
Insurance Co. Address					
Secondary Insurance					
Insured's Name			Relationship		
Birthdate					
Employer					
Insurance Co					
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Has	your child ever had any of	f the f	ollowing:					
YN		YN		ΥN		How often does your child brush? Floss?		
H	Aids/HIV	H	Developmental Delay	Ť	Mumps	Is brushing/flossing supervised? Y N By Whom?		
H	ADD/ADHD	H	Diabetes		Pneumonia	Is the child's water fluoridated? Y N Don't Know		
H	Anemia	T	Drug/Alcohol Abuse		Pregnancy	Is your child receiving fluoride supplements? Y N		
H	Allergy	T	Epilepsy		Psychiatric Disorder	· · · · · · · · · · · · · · · · · · ·		
H	Asthma	T	Endocrine		Rheumatic Fever	TabletsDrops Dose		
H	Autism	т	Eye Problems	\top	Scarlet Fever	Is this your child's first dental visit?		
Ħ	Bleeding Abnormalities	\Box	Fainting/Dizziness		Scoliosis	Previous Dentist		
H	Brain Injury	T	Hearing Loss	1	Sickle Cell Anemia	Date of last visitDate of last dental x-rays		
	Bronchitis	\Box	Heart Disease/Murmur		Sinus Problems/Snoring	Any injuries to your child's teeth or jaw? Y N		
	Cancer	\Box	Hemophelia		Sore Throat (frequent)	When/What?		
П	Cerebral Palsy	\Box	Hepatitis		Enlarged Tonsils/Adnoids	Has your child had recent dental pain? Y N		
	Chicken Pox		Jaundice		Spina Bifida			
	Cleft Lip/Palate		Leukemia		Tuberculosis	Explain		
	Communicable Disease	П	Measles		Other	Breast feeding (until age) Bottle (until age)		
	Convulsions/Seizures		Mental Retardation			Thumb/Finger Sucking Pacifier Nail Biting		
Plea	se explain any checked items				and the second second	Dental Grinding/Clenching Mouthbreathing/Snoring		
					The state of the s	Has your child experienced any unfavorable reaction from previous medical		
					A STATE OF THE STA			
Пτ	his child has never been d	iagnos	ed as having any of the a	bove	conditions.	or dental care? Yes No Explain		
П					A Property of the Property of			
Add	d's Physician ress e of last exam (list resu		<u> </u>			Phone #		
						·····		
Plea	se list any serious medi	ical pr	oblems, hospitalizatio	ns, s	urgeries that the child h	nas had		
Dlaa	ca list all madisations t	ha ch	ild is supportly taking	(Giv	a nagrans)			
			_					
Prer	nedication prior to den	tal tre	eatment? Yes _	_ N	o Why?			
Is y	our child under the car	e of c	specialist for any me	dica	reason? Yes No	o Why?		
						Phone #		
-								
Doe	s your child have a hist	ory of	· allergies/sensitivitie	s/ac	verse reactions to any dr	rugs or medications (Penicillin, Novocain, etc? Yes No		
(if y	res, please describe)							
Doe	s vour child have a hist	orv to	any other substances	s (lat	ex, environmental, etc.)?			
		-						
12 1	ne chila up to date on il	mmuri	12011011S? Yes	_ '\	Do you wish to speak	to the doctor privately about a special concern? YesNo		
Aut	horization and Relea	nse						
, , ,								
To t	he best of my knowledg	ge, th	e questions on this for	rm h	ave been accurately answ	vered. I understand that providing incorrect information can be		
dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the								
dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis								
and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health								
practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand								
that	t my insurance carrier n	nay po	ay less than the actual	bill	for services; I agree to b	be responsible for payment of all services rendered on my behalf or		
my o	dependents.							
•								
Siar	nature of Patient (or Pa	rent/	Guardian if minor)			 Date		
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Dan	tict's Daview							
UEN	IIDI 3 KEVIEW							
c:	nature of Nortist					Nata		
Jigr	nature of Dentist					Date		