



SHOAL CREEK PEDIATRIC DENTISTRY, LLC



The office of Dr. Scott Thomas
www.ShoalCreekSmiles.com
(816) 781-5437

Office use only

Today's Date: ____ / ____ / ____

Child's Weight (kg): _____

Information about your child:

Child's Name: _____ Preferred Name: _____ Gender: _____

(Nick Name)

Age: _____ Date of Birth: ____ / ____ / ____ School: _____ Grade: _____

Do we see any of this child's siblings (if yes please list): _____

Address at which child resides: _____ City: _____ State: ____ Zip: _____

Phone Number for this Address: _____

Please list any favorite interests such as favorite toys, activities or pets that may help us to make your child feel more at home: _____

Mothers Information: (Guardian / Stepmother

Name: _____ Birth Date: ____ / ____ / ____

Phone: _____ / _____
(Home) (Cell)

SS#: _____

Employer: _____ / _____
(phone #)

Fathers Information: (Guardian / Stepfather

Name: _____ Birth Date: ____ / ____ / ____

Phone: _____ / _____
(Home) (Cell)

SS#: _____

Employer: _____ / _____
(phone #)

Person Responsible for Account

Name: _____ Relation to Patient: _____

Billing Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ / _____ / _____
(Home) (Work) (Cell)

Person Responsible for making Appointments: _____ Phone: _____

Please indicate: Home, Work, or Cell

Insurance Information

Primary Insurance:

Insured's Name: _____

Date of Birth: ____ / ____ / ____

Relationship to patient: _____

Social Security #: _____

Employer: _____

Work Phone #: _____

Dental Insurance Company: _____

Phone #: _____

Insurance Company Address: _____

City: _____ State: ____ Zip: _____

Group #: _____

Secondary Insurance:

Insured's Name: _____

Date of Birth: ____ / ____ / ____

Relationship to patient: _____

Social Security #: _____

Employer: _____

Work Phone #: _____

Dental Insurance Company: _____

Phone #: _____

Insurance Company Address: _____

City: _____ State: ____ Zip: _____

Group #: _____



Medical History

Your child's overall health, as well as any medications your child may take, is important to the dental care they receive, please answer each question completely.

Do any of the following apply to your child?:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Autism | <input type="checkbox"/> Hearing or Vision Loss |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Thyroid or Endocrine Disorder | <input type="checkbox"/> ADHD | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Mental Disability | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy or Convulsions | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Hemophilia or Bleeding Dis. | <input type="checkbox"/> Mitochondrial Disorders | <input type="checkbox"/> Osteogenesis Imperfecta |
| <input type="checkbox"/> Cancer, Radiation, or Chemo | <input type="checkbox"/> Tuberculosis or Mononucleosis | <input type="checkbox"/> Neural Tube Defects | <input type="checkbox"/> Ectodermal Dysplasia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV or Aids | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Cleft Palate |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Immune Disorders | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Infective Endocarditis | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Cerebral Palsy | _____ |
| <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Muscular Dystrophy | _____ |

If you marked any of the conditions listed please elaborate as to the nature of the condition: _____

Is your child taking any medications (no / yes): _____

Is your child allergic to any medicines or food (no / yes): _____

Has your child had to take any type of antibiotic before dental procedures in the past (yes / no), if yes please explain below: _____

Has your child had any major surgeries or health problems now or in the past (yes / no), if yes please explain the nature of the surgery or health problem: _____

Name of your child's Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Dental History

Last Dental Visit: _____ / _____ / _____
(Name of the Dentist visited) (Approximate Date) (Phone #)

Has your child had a history of, or do they now exhibit any of the following habits (if yes please indicate length of habit):

- Thumb or finger Sucking Pacifier Use Lip Biting Nail Biting Length of habit: _____

My child's attitude toward dentistry is: Favorable Unfavorable Apprehensive

What is the purpose of your child's Dental visit today? Comprehensive Care Mouth or Tooth pain Trauma to teeth / gums

Other (Please Explain): _____

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. It is also my responsibility to inform this office of any changes in my child's medical status.

I authorize **Dr. Thomas** and his staff to perform the necessary dental services my child may need.

Signature of Parent and/or Guardian

Today's Date