CHILDREN'S DENTAL CENTER OF MADISON, S.C.

madisonkidsdentist.com

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7001 Old Sauk Road, Suite 200 • Madison, WI 53717-1010
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5116 American Family Drive • Madison, WI 53718-8331
608-825-7500 • Fax 608-825-0010

About Your Child

Child's Name: _____

Nickname: _____ ☐ Female ☐ Male

Child's Birthdate: ___/___/___ Age ____

SS#/Ins. ID_____

Does child live with ☐ Both Parents ☐ Mom ☐ Dad ☐ Guardian ☐ Foster Parents ☐ Stepmother ☐ Stepfather ☐ Other

Child's Address: _____

City _____ State ____ Zip _____

If child does not live with both parents please provide addresses of both parents.

Mom: _____

_____

Dad: _____

_____

Who is Accompanying the Child Today?

Name: _____

Relation to Child: _____

Name of person with legal custody of the child?

_____

Whom may we thank for referring your child?

_____

Other family members seen by us:

_____

_____

Legal Guardian

Mother's/Guardian's Name: _____ DOB ____/____/____

Mother's/Guardians Employer:_____ SS # _____

Telephone Numbers: Home _____ Cell _____ Work _____

E-mail:_____

Father's/Guardian's Name: _____ DOB ____/____/____

Father's/Guardian's Employer:_____ SS # _____

Telephone Numbers: Home _____ Cell _____ Work _____

E-mail:_____

Dental Insurance

Do you have dental insurance? Yes ☐ No ☐

Primary insurance co. name, address, phone. Ins. ID # _____

_____

_____

Subscriber for primary insurance is Mom ☐ Dad ☐ Other ☐

If other is checked provide us with their name, relationship to patient, social security #, employer and birthdate.

_____

_____

Secondary insurance co. name, address, phone. Ins. ID # _____

_____

_____

Subscriber for secondary insurance is Mom ☐ Dad ☐ Other ☐

If other is checked provide us with their name, relationship to patient, social security #, employer and birthdate.

_____

_____

Do you have Wisconsin Medical Assistance? ☐ Yes ☐ No

MA ID# _____

If you have WI Medical Assistance, you are required to bring your child's card to each appointment.

Alternate Contact Information

(Other than legal guardian)

Name: _____

Relation: _____

Home # _____

Cell #_____

Work #_____

Please Complete Backside

Dental History

Any current dental complaints? _____

Has the child ever had a problem associated with previous dental work? ☐ Yes ☐ No Specify if yes: _____

_____

Is the child's water fluoridated? ☐ Yes ☐ No
Is the child taking a fluoride supplement? ☐ Yes ☐ No If yes, what? _____
Does the child brush his/her teeth daily? ☐ Yes ☐ No
Floss his/her teeth daily? ☐ Yes ☐ No
Is this your child's first dental visit? ☐ Yes ☐ No
If no, who was the last Dentist? _____ Last visit date: _____

Oral Habits *(please indicate any history)*

Currently using bottle? Y N
If no, what age discontinued. _____
Currently breastfeeding? Y N
If no, what age discontinued. _____

Y N Thumb/Finger Sucking
Y N Nail Biting
Y N Lip Sucking/Biting
Y N Speech Impairment

Specify if yes to any questions
_____
_____
_____

Has the child ever had the following medical problems?

Please indicate any history of the following and write in detail (dates, etc.) below:

Y N ADD/ADHD	Y N HIV+/AIDS	Y N Anemia	Y N Shunts
Y N Heart Murmur	Y N Hemophilia	Y N Congenital Heart Defect	Y N Any stays in a hospital
Y N Cancer	Y N Asthma	Y N Convulsions/Epilepsy	Y N Kidney/Liver Problems
Y N Diabetes	Y N Hepatitis	Y N Abnormal Bleeding	Y N Handicaps/Disabilities
Y N Rheumatic Fever	Y N Tuberculosis	Y N Hearing Impairment	Y N Allergies
Y N Physical or psychological development delay		Y N Any Operations	Y N Autism/Autism Spectrum

Y N Other _____

Please discuss any medical problems the child has had: _____
Child's Physician: _____ Phone #: _____ Last Visit Date: _____
Any current medical complaints? _____

_____

Please list all drugs the child is currently taking: _____

_____

Drug allergies? ❑ Yes ❑ No If yes, indicate specific drugs: _____

_____

Latex allergy? ❑ Yes ❑ No

I understand the information I have given is to the best of my knowledge, that it will be held in the strictest of confidence, and 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 dental services my child may need. I accept full responsibility for full payment of the treatment performed. It is my understanding that two (2) consecutive broken appointments without explanation may lead to dismissal of my child as a clinic patient.

Signature _____ Date _____

Relationship to child _____

FINANCIAL POLICY

Payment is due when services are rendered. We accept cash, personal checks and all major credit cards. We realize that some procedures are more extensive than others and we will be more than willing to work out alternative financial arrangements prior to treatment. I understand and agree that, (regardless of my insurance status or marital status), I am ultimately responsible for the balance on this account for any professional services rendered.

I have read the above information and understand my obligations.

Signature of financially responsible party _____