Just Kids, Inc.

New Patient Questionnaire

Child's Name_____ **Nickname**_____
Birth Date_____/_____/_____ **Age**_____ **Sex**_____ **Weight**_____ **SSN#**_____-_____-_____
Child's Physician _____**Physician's Ph #**_____

Have any of your other children been to Just Kids Dental Office before? Yes No
If so, what are their names?_____
Has your child been to the dentist before? Yes No Last visit _____
Were x-rays taken? Yes No Date_____
Has your child ever injured their teeth? Yes No
If yes, explain: _____
Does (or did) your child have any of the following habits?
___Clenching or grinding teeth ___Finger or thumb habit
___Mouth breathing ___Pacifier

Medical History

Is your child in good health? Yes No
If no, please explain: _____
Is your child taking any medication? Yes No
If yes, please list: _____
Is your child sensitive/allergic to any medication? Yes No
If yes, please list: _____
Is your child sensitive/allergic to any foods? Yes No
If yes, please list _____
Is your child sensitive/allergic to **Latex?** Yes No
Does your child bruise easily? Yes No
Does your child bleed excessively when cut? Yes No
Was your child ever hospitalized or had surgery? Yes No
If yes, when: _____ Why: _____

Does your child have (or had) any of the following conditions:
If yes, state when diagnosed.
Any behavioral/neurological disorders (Autism, ADHD, Developmental Delay):_____

Asthma (or Reactive Airway Disease)	Yes No	Diabetes	Yes No
Heart murmur	Yes No	Digestive disorders	Yes No
Heart disease or defects	Yes No	Cancer	Yes No
Cerebral Palsy	Yes No	Rheumatic fever	Yes No
ADD/ADHD	Yes No	Allergies	Yes No
Seizures	Yes No	Liver disease	Yes No
Anemia	Yes No	Kidney disease	Yes No
Tuberculosis (or exposure)	Yes No	AIDS/HIV positive	Yes No
Hepatitis A, B or C	Yes No	Auto Immune disorder	Yes No
Frequent ear infections	Yes No	Blood disorder	Yes No

Any other condition not listed above: _____
Additional Comments or Remarks: _____
_____

The signature of the parent/guardian below authorizes dental providers at Just Kids Inc. to perform routine dental exams, x-rays, cleanings and required dental treatment.

_____ _____
Signature Date Relationship to patient