Just Kids, Inc.

Health History & Practice Updates/Agreements

Child's Name_____ **Nickname**_____
Birth Date_____/_____/_____ **Age**_____ **Sex**_____ **Weight**_____ **Phone #** _____
Child's Physician _____ **Physician's Ph #**_____
Preferred Language_____ **Would you like us to provide translation?** _____
Phone Number _____ **Email**_____

Has your child injured their teeth since their last visit? 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
Digestive disorders	Yes	No	Rheumatic fever	Yes	No
Cancer	Yes	No	Allergies	Yes	No
Cerebral Palsy	Yes	No	Liver disease	Yes	No
ADD/ADHD	Yes	No	Kidney disease	Yes	No
Seizures	Yes	No	AIDS/HIV positive	Yes	No
Anemia	Yes	No	Auto Immune Disorder	Yes	No
Tuberculosis (or exposure)	Yes	No	Blood disorder	Yes	No
Hepatitis A, B or C	Yes	No	Frequent ear infections	Yes	No
Heart Murmur/Disease/defect?	Yes	No			
If Yes is Pre-Med Required?	Yes	No	Name of Cardiologist: _____		

Any other condition not listed above: _____

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. I am aware of the minimum 24-hour cancelation policy of Just Kids and am aware if I do not give 24 hours' notice prior to cancelation I could be charged a deposit of $25 per child to reschedule which is non-refundable if the scheduled appointment is missed again. I am also aware that if I do not call in advance to cancel my family could be dismissed from the Just Kids practice.

_____ _____ _____
Signature Relationship to patient Date

I hereby authorize my insurance company to make payment directly to Just Kids, Inc., and authorize the release of any necessary and pertinent documents. As the parent/legal guardian of a minor patient, I hereby agree to accept financial responsibility for dental treatment provided by Just Kids, Inc. I acknowledge that I am financially responsible for all charges whether or not paid by insurance.

_____ _____ _____
Signature Printed Name Date