Dr. K.B. Chun & Sons Dentistry

MINOR/CHILD INFORMATION

Date: _____

Legal Name of Minor/Child (Last, First, M.I.):

_____

Nickname/Preferred Name:_____

Sex: ☐M ☐F Age:_____ Birthdate:_____

Hobbies:_____

Mailing address:_____

City:_____ State:_____ Zip:_____

Parent/Guardian Information

- **Father**/Guardian Name (Last, First, M.I.):

_____

Address (if different from above):

_____

Birthdate:_____ SS#_____

Employer:_____

Occupation:_____

- **Mother**/Guardian Name (Last, First, M.I.):

_____

Address (if different from above):

_____

Birthdate:_____ SS#_____

Employer:_____

Occupation:_____

DENTAL INSURANCE

Who is financially responsible for this account?:

_____

Relationship to Patient:_____

Whom may we thank for referring you?:

_____

Primary Insurance

Insurance Company:_____

Group #:_____

Subscriber ID#:_____

Subscriber Name (Last, First, M.I.):

_____

Relationship to Patient:_____

Birthdate:_____ SS#:_____

Secondary Insurance

Insurance Company:_____

Group #:_____

Subscriber ID#:_____

Subscriber Name (Last, First, M.I.):

_____

Relationship to Patient:_____

Birthdate:_____ SS#:_____

CONTACT INFORMATION

Patient's Home Ph:_____ Father Cell Ph: _____ Father Work Ph: _____(Ext:_____)

Mother Cell Ph: _____ Mother Work Ph:_____(Ext:_____)

Best time and place to reach you:_____

We now offer text & e-mail messaging confirmation; would you like to receive texts/e-mails to remind you of your appointments?

☐ YES ☐ NO If YES, please list the cell phone number/e-mail you wish to receive reminders on: _____

In case of an emergency, contact:

Name:_____ Relationship to patient:_____

Home Ph: _____ Cell Ph: _____ Work Ph: _____ (Ext:_____)

Please complete both sides

Patient Name:_____

MEDICAL HISTORY

Minor/Child's Physician:_____ City/State:_____ Phone:_____

Date of last physical examination:_____ Results:_____

	YES	NO		YES	NO
Is Minor/Child under care of physician now?.....	☐	☐	Ever had surgery?.....	☐	☐
Please explain:_____			Please explain:_____		
Ever been hospitalized?.....	☐	☐	Receiving any medications or drugs?.....	☐	☐
Please explain:_____					
Is there excessive bleeding when cut?.....	☐	☐			

- Please list any medications Minor/Child is currently taking:_____

_____

- Please list any allergies Minor/Child has:_____

_____

Has Minor/Child had any history of or difficulty with any of the following? If YES, please mark the appropriate box(es):

☐ A.I.D.S./H.I.V.	☐ Chicken Pox	☐ Heart Problems	☐ Sinus Problems
☐ Anemia	☐ Convulsions	☐ Hepatitis	☐ Thyroid Disease
☐ Asthma	☐ Diabetes	☐ Kidney Disease	☐ Tuberculosis
☐ Autism	☐ Down Syndrome	☐ Liver Disease	☐ Other:_____
☐ Bladder Problems	☐ Drug/Alcohol Abuse	☐ Measles	_____
☐ Blood disorder	☐ Epilepsy	☐ Mononucleosis	_____
☐ Cancer	☐ Fainting	☐ Mumps	_____
☐ Cerebral Palsy	☐ Hearing Problems	☐ Rheumatic Fever	

DENTAL HISTORY

Date of last visit to a dentist:_____ For what service?:_____

	YES	NO		YES	NO
Has child complained about dental problems?....	☐	☐	Is fluoride taken in any form?.....	☐	☐
Does child brush teeth daily?.....	☐	☐	Any injuries to mouth, teeth, head?.....	☐	☐
Does child floss teeth daily?..... .	☐	☐	Any unhappy dental experiences?.....	☐	☐
Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?.....				☐	☐

To the best of my knowledge, the preceding information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes in my medical/dental history.

Parent/Guardian Signature_____ Date_____

(Update)_____ Date_____

(Update)_____ Date_____

(Update)_____ Date_____

(Update)_____ Date_____