DENTISTRY FOR KIDS
1439 S St. Francis Dr, Santa Fe, NM 87505
(505) 473-5437

DENTISTRY FOR KIDS *SOUTHSIDE*
6640 Cerrillos Rd., Ste E, Santa Fe, NM 87507
(505) 473-5437

PATIENT INFORMATION

Date: _____

Name _____ Preferred Name _____
Birthdate _____ Male _____ Female _____ NB _____
Child's Social Security Number _____ Current Age _____
Name of Parent/Guardian filling out form _____
Parent/Guardian #1 Name _____ Marital Status _____
Parent/Guardian #1 Social Security Number _____ Parent/Guardian #1 Birthdate _____
Parent/Guardian #1 Mailing Address _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____ Preferred Contact Number (check one): Home _____ Cell _____
Email Address _____
Do you allow us to contact you via email or text to communicate patient information? ☐ YES ☐ NO
Parent/Guardian #2 Name _____ Marital Status _____
Parent/Guardian #2 Social Security Number _____ Parent/Guardian #2 Birthdate _____
Parent/Guardian #2 Mailing Address _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____ Preferred Contact Number (check one): Home _____ Cell _____
Email Address _____
Do you allow us to contact you via email or text to communicate patient information? ☐ YES ☐ NO

DENTAL INSURANCE INFORMATION

If you receive financial assistance for your child's dental care, please check the option that applies:

Medicaid _____ CMS _____ Project ANN _____ Other _____

Primary Policy Information

Name of Policy Holder _____
Insurance Name _____ Insurance Phone Number _____
Member ID _____ Group # _____
Policy Holder's Birthdate _____
Policy Holder's Social Security Number (required to file claims) _____
Employer _____
Phone _____
Person other than spouse to be notified in case of an emergency _____
Phone _____
Medical Physician _____ Phone _____

Secondary Policy Information

Name of Policy Holder _____
Insurance Name _____ Insurance Phone Number _____
Member ID _____ Group # _____
Policy Holder's Birthdate _____
Policy Holder's Social Security Number (required to file claims) _____
Employer _____

Patient Name _____

Is this your child's first visit to a dentist? yes ☐ no ☐

Was your previous dentist experience: good ☐ bad ☐ other ☐ Explain: _____

Please tell us the main reason for today's visit: _____

_____

Has your child been experiencing dental pain? yes ☐ no ☐

Has your child been awake at night from dental pain? yes ☐ no ☐

Do you have any concerns about your child's dental health? _____

Has your child ever been hospitalized? yes ☐ no ☐ If yes, please give date(s) & reasons:

_____

Is your child allergic to any medications? yes ☐ no ☐ If yes, please identify: _____

_____

Is your child currently taking any medications? yes ☐ no ☐ If yes, please identify: _____

Reason for medication _____

Pediatrician Name _____ Phone _____

Has your child been immunized for: DPT: yes ☐ no ☐

Polio: yes ☐ no ☐

Measles, Mumps & German Measles: yes ☐ no ☐

Is there anything you can tell us about your child that could assist us in taking the best possible care of them? _____

_____

HEALTH HISTORY

This information will be confidential and is necessary to allow us to give your child our best treatment. Please check yes or no to whether your child have or have they ever had in the past any of the following:

YES	NO		YES	NO	
☐	☐	Speech problems	☐	☐	Anemia/Sickle Cell Disease
☐	☐	Cerebral Palsy	☐	☐	Hearing problems
☐	☐	Bruises easily	☐	☐	Seizures
☐	☐	Asthma	☐	☐	Blood transfusion
☐	☐	Kidney/bladder problems	☐	☐	Skin problems
☐	☐	Hepatitis/jaundice	☐	☐	Diabetes
☐	☐	Cystic Fibrosis	☐	☐	Pregnancy (patient)
☐	☐	Allergies, if so, what: _____			

Has patient had heart disease or a heart murmur? yes ☐ no ☐ If yes, please describe: _____

_____

Is pre-medication required for dental treatment? yes ☐ no ☐ Preferred drug: _____

Child's weight: _____

Please *check* all illnesses your child has previously had:

☐ Chicken Pox ☐ Ear Aches ☐ Measles ☐ German Measles ☐ Mumps ☐ Mononucleosis ☐ HIV/AIDS ☐ Scarlet Fever
☐ Tuberculosis ☐ Venereal Disease ☐ Tonsillitis

Learning or behavior disorders: yes ☐ no ☐ If yes, what: _____

Has your child had any prior surgeries? yes ☐ no ☐ Is your child currently scheduled for surgery? yes ☐ no ☐

If yes, describe/date: _____

Is your child a picky eater? yes ☐ no ☐

Is there anything else we should know about your child? _____

_____

Parent/Guardian Signature: _____

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Patient Name:_____Date of Birth:_____

Parent Name: _____Phone number:_____

- Do you have concerns with your child's ability to understand or communicate?
  ☐Yes☐No
- Do you have a hard time getting your child to eat a variety of foods?
  ☐Yes☐No
- Does your child have difficulty sitting still?☐Yes ☐No
- Does your child have difficulty paying attention or following directions?
  ☐Yes☐No
- Has your child been diagnosed with Autism?☐Yes☐No
- Has your child been diagnosed with ADD/ADHD? ☐Yes ☐No
- Does your child have any balance or coordination concerns?☐Yes ☐No
- Any difficulty with sitting up, crawling, walking or rolling?☐Yes ☐No

Dentistry for Kids (DFK) prides itself in a wholistic approach to treating children. We partner with other providers to help your child be most successful.

By signing below you are giving permission for DFK to share this information with our partnered agencies to better assist your child. They may contact you to offer their assistance.

_____

Parent/Guardian Signature Date

Dentistry for Kids delivers dental care in a compassionate individualized way, promoting and restoring ideal oral form and function to New Mexico's children. We are educated, responsible, available and consistent in our services. Our emphasis is on preventative care and the links between oral health and overall health. All of our locations deliver the same excellent dental care.