Welcome to Star Kids!

At Star Kids Pediatric Dentistry We Are Committed To Providing Quality Dental Care To Create A Safe, Fun And Comfortable Dental Experience For Your Child.

Your Child

Name _____ Nickname _____ DOB _____ Age _____

SS# _____ Male_____ Female_____ Child lives with _____

What language does your child prefer? _____ Child's hobbies/interests _____

Father ___ Stepfather ____ Guardian ____ (Must provide proof of guardianship) Custodial Parent? ____Yes ____ No
Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Name _____ **email** _____

Address _____ City _____State _____ Zip_____

Date of Birth _____ Social Security # _____-_____-_____ Driver's License # _____

Home Phone #_____ Cell # _____ Work Phone # _____

Employer _____ Occupation _____

☐ Check this box if you DO NOT want to receive email or Text communications from Star Kids Pediatric Dentistry.

Mother ___ Stepmother ____ Guardian ___ (Must provide proof of guardianship) Custodial Parent? ____Yes ____ No
Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Name _____ **email** _____

Address _____ City _____State _____ Zip_____

Date of Birth _____ Social Security # _____-_____-_____ Driver's License # _____

Home Phone #_____ Cell # _____ Work Phone # _____

Employer _____ Occupation _____

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Whom may we contact if you cannot be reached or in case of emergency?

Name: _____ Phone #_____ Relation _____

Who referred you to our office? _____

Primary Dental Insurance: TX Medicaid ___ TXCHIP ___ NM Medicaid ___Other _____

Insured's Name _____ Relationship to patient _____

Date of Birth _____ Social Security # _____-_____-_____

Is there **secondary** Dental Insurance coverage? No ____ Yes _____

Primary Medical Insurance: TX Medicaid ___ TX CHIP ___ NM Medicaid ___Other _____

Insured's Name _____ Relationship to patient _____

Date of Birth _____ Social Security # _____-_____-_____

Is there secondary Medical Insurance coverage? No ___ Yes _____

Payment is required in full at each appointment. For your convenience, we accept:
-Cash -Personal Checks -Debit/Credit Cards -Care Credit

Medical Questionnaire **Patient's Name: _____ DOB: _____**

Child's Physician _____ Phone #_____
Child's Specialist _____ Phone #_____
Has your child been hospitalized? ___ No___ Yes, explain _____
Have you ever been told your child has a heart murmur? ___ No___ Yes, explain _____
Is your child currently being treated by a physician? ___ No ___ Yes, explain _____
Does your child have any allergies? ___ No ___ Yes, explain _____
Has your child ever experienced an unfavorable reaction to medications, antibiotics, or local anesthesia? ___No ___Yes
Explain_____
Has your child ever undergone general anesthesia? ___ No ___Yes, explain _____
Has your child or anyone in your family had problems with general anesthesia? ___No___ Yes, explain _____
Is your child currently taking any medications? ___No __Yes, List them _____
Does your child have a history of developmental or behavioral problems? ___No ___Yes, explain _____
What is your child's intellectual level? ___Above Average ___Average ___Below Average ___Learning Disabled ____School grade
Is your daughter pregnant ____Yes ____No ___N/A

Does your child have a history or existing condition with any of the following?

___AIDS	___Bleeding Disorder	___Cleft Palate/Lip	___Heart Condition	___Seizures/Epilepsy
___ADD/ADHD	___Cancer/Malignancies	___Diabetes	___Kidneys	___Thyroid
___Asthma	___Cerebral Palsy	___Down Syndrome	___Liver/Hepatitis	___Tuberculosis
___Autism	___Chronic Sinus	___Ears/Hearing	___Rheumatic Fever	

Other: _____

Dental Questionnaire

Last visit to the dentist: Date_____ Dentist_____ Services Rendered_____
Does your child have dental complaints? ___No ___Yes, Explain_____
Any injuries to the teeth, mouth or head? ___No ___Yes, Explain_____
Does your child have any of the following?

___Pain	___Swelling	___TMJ/Joint Problems		___Bruxism (Grinding)	___Headaches	
___Bottle	___Nursing	___Pacifier	___Thumb Sucking	___Finger Sucking	___Lip Biting	___Nail Biting

Does your child brush daily? ___No ___Yes Does your child floss? ___No ___Yes
Is Fluoride taken in any form? ___No ___Yes, In what form? _____
What is your child's attitude towards dentistry? _____
Do you desire complete dental service for your child? ____Yes ____ No, explain_____

Authorization and Acknowledgement – PLEASE INITIAL EACH STATEMENT

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize Dr. Holguin, Dr. Latoya Delaughter Dr. Edith Osorio, Dr. Courtney Brooks, Dr. Carolyn Muckerheide, Dr. Anahi Garcia-Labori , Dr. Edgar Perales, Dr. Yanitza Feliciano and or the dental staff to perform the necessary services my child may need.

____ I authorize my child's Physician, Specialist and/or previous Dentist listed above, to release any information or records necessary to Star Kids Pediatric Dentistry in the course of treatment for my child.

____ I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I have been advised and understand that I am responsible for any balance on my account.**

____ I agree that all medical records and x-rays taken in this office or by any other facility, whether or not paid for by the undersigned, shall become a part of the doctor's professional records and shall be subject solely to his control and disposition. I understand that a base fee of $30.00 will be charged for duplicate records.

____ I authorize the doctors to use photographs, radiographs, other diagnostic aids and treatment records for the purposes of teaching, research and scientific publications.

_____ _____ _____
Signature of Parent or Guardian Date Witness