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.

Patient

First Name _____ Last Name _____ DOB _____ Age _____

SS# _____ ___Male ___Female Child lives with _____

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

Parent 1 ___Stepparent ___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 St # _____

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.

Parent 2 ___Stepparent ___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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In case of an emergency, whom may we contact if you cannot be reached?

Name: _____ **Phone #**_____ **Relation** _____

****FAILURE TO DISCLOSE ALL AVAILABLE INSURANCE COVERAGE, WILL RESULT IN YOUR BALANCE ****

Primary Dental Insurance: _____

Insured's Name _____ Relationship to patient _____

Date of Birth _____ Social Security # _____

*Is there **secondary** Dental Insurance coverage? ___No ___Yes, _____

Primary Medical Insurance: _____

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 -Debit/Credit Cards -CareCredit Card

CareCredit Refund Policy: Any Credit on transactions made with the Care Credit Card will be refunded to the CareCredit Card.

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

Other: _____

Who referred you to our office? _____

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	___ Pacifier
___ Bottle	___ Nursing	___ 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

- 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. Lizbeth Holguin, Dr. Latoya Delaughter, Dr. Edith Osorio, Dr. Courtney Brooks, Dr. Carolyn Muckerheide, Dr. Edgar Perales, Dr. Yanitza Feliciano, Dr. Michael Silva, 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 reasonable fee 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