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 ____Other 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 CareCredit 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_____

Has your child experienced an unfavorable reaction/allergy to medication, anesthesia, weather, food, etc.? ___ 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: _____

Are your child's vaccines up to date? ___ Yes ___ No, Explain _____

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 ___ Developmental Delay
___ADD/ADHD ___Cancer/Malignancies ___Diabetes ___Kidneys ___Thyroid ___Speech Delay
___Asthma ___Cerebral Palsy ___Tuberculosis ___Down Syndrome ___Liver/Hepatitis ___Behavior Problems
___Autism ___Chronic Sinus ___Ears/Hearing ___Rheumatic Fever ___ Snoring/ Sleep Apnea ____GERD
___Born Premature- At how many weeks? _____

Other: _____

Who referred you to our office? _____ **Why?** _____

Do you desire complete dental service for your child? ___ Yes ___ No, Explain _____

Dental Questionnaire

Last visit to the dentist: Date_____ Dentist_____ Services Completed_____

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

Do any of the following apply: ___ Nursing ___ Bottle ____ Sippy Cup

Habits: ___ Pacifier ___ Thumb Sucking ___ Finger Sucking ___ Nail biting ___ Lip Biting

Other: _____

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? _____

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. Edith Osorio, Dr. Yanitza Feliciano, Dr. Perales, 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