

**David J. Kristoff D.D.S.**  
**Donald Hanson D.D.S.**  
**1040 N. Rangeline Road, Carmel, IN 46032**  
**317-846-3436**  
**Patient's Clinical History/Personal Information (Child)**  
**(Please complete in ink)**

Name \_\_\_\_\_ I prefer to be called \_\_\_\_\_ Sex \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Street City Zip

School \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Where and when are the best times to reach you? \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Do you have legal custody of this child?  Yes  No Is the child adopted?  Yes  No

Parents Marital Status:  Single  Married  Separated  Divorced  Widowed  Remarried

Father  Step Father  Guardian

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Street City Zip

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Mother  Step Mother  Guardian

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Street City Zip

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

**Primary Dental Insurance:**

Insurance Co. Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Group/policy # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Secondary Dental Insurance:**

Insurance Co. Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Group/policy # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Person responsible for account**     Self     Other (please give information below)

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Driver License # \_\_\_\_\_ ( )

Address \_\_\_\_\_ Relation \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

## Medical History

**Family Physician** \_\_\_\_\_ Office Phone ( ) \_\_\_\_\_

Please circle any conditions, which the patient has had or has at present:

Heart Murmur	Heart Surgery	Anemia or Hemophilia	Cortisone medicine	Chemotherapy
Artificial Heart Valve	Bruise Easily	Kidney trouble	Glaucoma	HIV Positive/AIDS
Rheumatic Fever	Shortness of Breath	Diabetes	Arthritis or Rheumatism	Venereal Disease
Artificial Hip	Swelling of Ankles	Sickle Cell Disease	Pain in Jaw Joints	Herpes (Any kind)
Artificial Knee	High Blood Pressure	Liver Disease	Fainting or Dizzy Spells	Cold Sores
Heart Attack or Stroke	Lung Disease	Hepatitis	Alcoholism	Canker sores
Heart Pacemaker	Emphysema	Yellow Jaundice	Drug Addiction	Skin Rashes or Hives
Chest Pains (Angina)	Tuberculosis (T.B.)	Blood Transfusion	Cancer or Tumor	Epilepsy or Seizures
Heart condition	Asthma or Hay Fever	Thyroid Disease	Radiation Therapy	Psychiatric Treatment

Please comment on any conditions that have been circled (when it was diagnosed and how it is/was treated):

\_\_\_\_\_  
\_\_\_\_\_

Please List Any:

**Medications** (Dosage and Frequency)

**Allergies**

_____	_____
_____	_____
_____	_____
_____	_____

Please list any other significant information about the patient's Medical History: \_\_\_\_\_

\_\_\_\_\_

**Yes    No**

- Is the patient under a physician's care at present? If yes, reason \_\_\_\_\_
- Has the patient ever been hospitalized or had surgery? If yes, reason \_\_\_\_\_
- Has the patient ever had a reaction to local anesthetic? If yes, describe \_\_\_\_\_
- Has the patient ever had hip or knee surgery or been diagnosed with a heart murmur?
- 

## Dental History

**Previous Family Dentist** \_\_\_\_\_ Office Phone ( ) \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

What is the main dental concern that you would like to have addressed? \_\_\_\_\_

\_\_\_\_\_

Are there any other dental issues that interest you or that you would like to learn more about? \_\_\_\_\_

Yes No

- Do any of the patient's teeth hurt? If yes, how long? \_\_\_\_\_
- Are any of the patient's teeth sensitive to sweets or cold? If yes, how long does the sensation last? \_\_\_\_\_
- Have there been any injuries to the patient's mouth or teeth? If yes, describe \_\_\_\_\_
- Has the patient ever had any injury to the head and neck area? If yes describe \_\_\_\_\_
- Has the patient ever fallen and bumped their chin, or received a blow to the jaws? If yes, describe \_\_\_\_\_

Yes No

- Has the patient ever had any surgery in the head and neck area? If yes, describe \_\_\_\_\_
- Has the patient ever had complications or illness following dental treatment? If yes, when \_\_\_\_\_
- Has the patient ever been told they have periodontal disease (gum disease)? If yes, describe \_\_\_\_\_
- Does it hurt to chew? If yes, where does it hurt? \_\_\_\_\_
- Does the patient hear clicking, popping, or grating sounds in the jaw joints? If yes, describe \_\_\_\_\_
- Has the patient ever been required to take antibiotics before visiting the dentist? If yes, why? \_\_\_\_\_
- Does the patient drink bottled water? \_\_\_\_\_
- If not in school, does the patient attend day care or preschool? \_\_\_\_\_

Does the patient have any of the following habits?

- Clenching/Grinding
- Finger/Thumb sucking
- Lip biting
- Nail biting
- Gum chewing
- Ice chewing

Any information you can give us concerning your child will be appreciated. The more we know about each patient, the more help we can give in managing the dental treatment, both at home and in the office. Also, please include special interests and hobbies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\*\*\*Whom may we thank for referring you to our office? \_\_\_\_\_

I have read the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes in my clinical history, I understand that it is my responsibility to inform Dr. Kristoff/Dr. Hanson. I also give permission for Dr. Kristoff/Dr. Hanson to perform a clinical examination and to make recommendations for treatment.

\*\*\*\*I have chosen the dental provider: Dr Kristoff /Dr. Hanson Family Dentistry of my own free will.

**X** \_\_\_\_\_ (please initial)

I certify that I am covered by \_\_\_\_\_ insurance company and I assign directly to Dr. \_\_\_\_\_ all insurance benefits otherwise payable to me.

I understand I am responsible for payment of services rendered and also responsible for paying any fees, co-payment and deductible that my insurance does not cover. **I understand I am responsible for any collection agency fees and/or a fee for missed appointments if 24 hours notice is not given (48 hours notice for Saturday appointments).** I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I acknowledge that I have received a copy of Dr. Kristoff "Notice of Privacy Act" – HIPPA ACT and Dr Kristoff's Office Financial Guidelines.

**X** \_\_\_\_\_  
(Signature of Responsible Adult)

\_\_\_\_\_  
Date