Kristoff Family Dentistry

David J. Kristoff, DDS

1040 N Range Line Road, Suite B, Carmel, IN 46032

Phone: 317-846-3436 www.kristoffdds.com Fax: 317-846-3596

Child Clinical History/Family Information (Please complete in ink)

Patient's Name____M.I.____Prefer to be called________________________

Gender_______Age__________Birth Date________________________Cell #______________________

Address____City________________State____________Zip___________

School ____Grade___________________________

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

Social Security Number of Patient **(for accounting purposes only)**____

Parents Marital Status: Single Married Separated Divorced Widowed

Responsible Party Information

Name___________________________________Birth Date__________________Relationship to patient______________

Address____City________________State____________Zip___________

Cell#____________________________Home#___________________________Work#___________________________

Email____

Employed by____Occupation_________________________

Social Security Number of Spouse **(for accounting purposes only)**____

Preferred phone number to call for appointments ________________________________

Other Parent's Information

Name___________________________________Birth Date__________________Relationship to patient______________

Address____City________________State____________Zip___________

Cell #____________________________Home#___________________________Work#___________________________

Email____

Employed by____Occupation_________________________

Social Security Number of Spouse **(for accounting purposes only)**____

How did you hear about our office?____

Primary Dental Insurance

Insurance Company________________________________Phone#_____________________Group#_____________________

Subscribers Name____Subscribers ID#______________________

Secondary Dental Insurance

Insurance Company________________________________Phone#_____________________Group#_____________________

Subscribers Name____Subscribers ID#______________________

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's information. I understand that Kristoff Family Dentistry may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Kristoff Family Dentistry all insurance payments otherwise payable to me. Insurance is submitted as a courtesy and payment is due in full within 30 days of appointment. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. **Please be aware that the parent bringing the child in for care is the one legally responsible for the payment of all fees. I affirm that my signature represents my agreement to all of the terms mentioned above.**

Signature____**Relationship**_________________________**Date**__________________

Patient's Family Physician____**Phone #**_____________________

<u>Medical History</u>

Have you had or do you currently have any of the following?

	Yes	No
Rheumatic Fever	☐	☐
Artificial Heart Valve	☐	☐
Congenital Heart defect	☐	☐
Heart Murmur	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Pacemaker	☐	☐
Radiation Treatment	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
Asthma	☐	☐
Blood Disorder	☐	☐
AIDS/HIV Infection	☐	☐
Hepatitis A, B, C	☐	☐
Diabetes	☐	☐
Ulcers	☐	☐
Herpes (any type)/cold sores	☐	☐
Cerebral Palsy	☐	☐
Cancer	☐	☐
Heart Disease	☐	☐
Anemia	☐	☐

	Yes	No
Autistic Spectrum Disorder	☐	☐
Chemotherapy	☐	☐
Human Papilloma Virus HPV	☐	☐
Neck Pains	☐	☐
Nerve or Brain Disease	☐	☐
Mitral Valve Prolapse	☐	☐
PRE-MEDICATE	☐	☐
Sinus Problems	☐	☐
Migraine	☐	☐
Blood Thinners	☐	☐
Epilepsy/Seizures	☐	☐
Mental Health Problems	☐	☐
Bone Disorders	☐	☐
Arthritis (any type)	☐	☐
Artificial Joints	☐	☐
Sleep Apnea	☐	☐
Heart Surgery	☐	☐
Kidney Problems or Disease	☐	☐
Thyroid Disease	☐	☐

Other________________________

Please comment on any condition you have checked (Date of diagnosis and treatment) ______________________________

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Please list all:

Medications (Dosage and Frequency) **Including Vitamins** | **Allergies**

_______________________________________ | ______________________________

_______________________________________ | ______________________________

_______________________________________ | ______________________________

Yes	No	
☐	☐	Is your child under a physician's care at present? If yes, reason______________________
☐	☐	Has your child ever been hospitalized or had surgery? If yes, reason____________________
☐	☐	Has your child ever had a reaction to local anesthetic? If yes, describe_________________
☐	☐	Is your child presently, or ever been under the care of a psychiatrist or psychologist? If yes, describe______________________________
☐	☐	Has your child ever taken Fen-Phen or Redux?
☐	☐	Is your child subject to profuse bleeding?
☐	☐	Is your child subject to nervous disorders?
☐	☐	Is your child subject to fainting or dizziness?

FEMALE PATIENTS

Yes	No	
☐	☐	Is there a possibility that your child could be pregnant?
☐	☐	Does your child use oral contraceptives?

DENTAL HISTORY

Yes	No	
☐	☐	Is this the child's first visit to a dentist? If no, how long since the last visit to the dentist_______________
		When was the last time the teeth were cleaned?_______________________________
☐	☐	Does child eat between meals?
☐	☐	Does child eat sweets (candy, gum, soda)?
☐	☐	Does child eat well balanced meals?
		Does child brush teeth…
☐	☐	Upon waking up?
☐	☐	When going to bed?
☐	☐	After eating any food?
☐	☐	Do you live in an area with fluoridated water?
☐	☐	Has your child's teeth been treated with fluoride?
☐	☐	Have cavities been noted in the past?______________________________
☐	☐	Were any teeth removed by extraction?______________________________
☐	☐	Was it suggested that space be maintained?
☐	☐	Was an appliance placed?
☐	☐	Have there been any injuries to teeth (chips, blows, falls)? If so, please describe____________________ ______________________________
☐	☐	Has your child had any unfavorable dental experiences?____________________ ______________________________
☐	☐	Has anyone in your family had orthodontics?
☐	☐	Has your child ever had occlusal sealants?

Does your child have any of the following habits?

Yes	No	
☐	☐	Finger/Thumb sucking
☐	☐	Lip Biting
☐	☐	Nail Biting
☐	☐	Gum Chewing
☐	☐	Ice Chewing

We recognize that patients sometimes have specific concerns that may not be addressed in this form. Please feel free to include any other information regarding your clinical history, or any other concerns you may have in the space below.

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

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

X____________(Parent/Guardian initial)

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

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's "Notice of Privacy Act" – HIPPA ACT and Dr. Kristoff's Office Financial Guidelines.

I understand that 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 2 business days' notice is NOT given.

X____ ___________________________

(Parent/Guardian signature) (Date)