**Kansas City Pediatric Dentistry LLC**
3801 Southwest Trafficway • Kansas City, MO 64111 • (816) 622-2000

THE FOLLOWING INFORMATION AND HISTROY ARE NECESSARY FOR TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

# Family Registration

**CHILD 1** : _____ Preferred Name_____

Date of Birth _____ Gender_____

**CHILD 2**: _____ Preferred Name_____

Date of Birth _____ Gender_____

**CHILD 3**: _____ Preferred Name_____

Date of Birth _____ Gender_____

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Whom may we thank for referring you to our office?

☐ Doctor _____ ☐ Friend _____

☐ Website ☐ Drive by ☐ Insurance ☐ Other: _____

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**Parent/Guardian's 1:** _____ E-mail_____

Address _____
Street City State Zip

Date of Birth _____Gender _____ Social Security #_____

Employer/Occupation _____

Dental Insurance _____
Company Subscriber #

Major Medical Insurance _____
Company Subscriber #

Parent Dentist _____

**Parent 1 Phone Number _____** **Appointment Related SMS/Text Opt-in ☐ YES**

Checking [YES] to this agreement authorizes Kansas City Pediatric Dentistry LLC at 816-622-200 to send SMS messages to your number for appointment reminders and status updates. Message frequency varies, and data rates may apply. You may request a copy of our privacy policy and terms at any time. Replying to our messages with STOP will cancel your subscription. You may also call us directly at 816-622-2000. Frequency may vary. Message and Data Rates may apply. Reply STOP to Cancel, HELP for help.

SMS Privacy www.pediatricdentistkc.com/smsprivacy.html SMS Terms www.pediatricdentistkc.com/SMSterms.html


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**Parent/Guardian's 2:** _____ E-mail _____

Address _____
Street City State Zip

Date of Birth _____ Gender _____ Social Security #_____

Employer/Occupation _____

Dental Insurance _____
Company Subscriber #

Major Medical Insurance _____
Company Subscriber #

Parent Dentist _____

**Parent 2 Phone Number _____** **Appointment Related SMS/Text Opt-in ☐ YES**

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# Patient Medical History

Child's Name_____

Child's Physician_____Practice Name_____

Physician's Address _____
Street City State Zip

## Health History

| | Yes | No | |
|---|---|---|---|
| Is your child in good health? | ☐ | ☐ | |
| Does your child have regular medical exams? | ☐ | ☐ | When was the last exam?_____ |
| Is your child up-to-date with immunizations? | ☐ | ☐ | |
| Is your child presently undergoing medical treatment? | ☐ | ☐ | If so, for what?_____ |
| Has your child been hospitalized since birth or had any operations? | ☐ | ☐ | Date/Reason_____ |
| Does your child have any infectious diseases? | ☐ | ☐ | If yes, list_____ |
| Is your child presently taking medications? | ☐ | ☐ | If so, what?_____ |
| Have there been any unfavorable reactions to medications? | ☐ | ☐ | If so, what?_____ |
| Is your child allergic to latex? | ☐ | ☐ | |
| Does your child have any other allergies? | ☐ | ☐ | If so, what?_____ |

## Health History

Check conditions that your child has currently or been affected by in the past.

| | | | | |
|---|---|---|---|---|
| ☐ADD/ADHD | ☐Blood Transfusions | ☐Chemotherapy | ☐Pregnancy | ☐Arthritis |
| ☐Asthma | ☐Kidney Problems | ☐Transplant Surgery | ☐Stomach Problems | ☐Cancer |
| ☐Emotional Disorder | ☐Special Ed Classes | ☐HIV/AIDS | ☐Autoimmune Disorder | ☐Bruise Easily |
| ☐Epilepsy/Seizure | ☐Speech Disorder | ☐Hepatitis A-B-C | ☐Fetal Alcohol Syndrome | ☐Leukemia |
| ☐Hearing Condition | ☐Speech Therapy | ☐Vision Disorder | ☐Eating Disorders | ☐NEED antibiotics |
| ☐Frequent headaches | ☐Tuberculosis | ☐Sleep Apnea/Snoring | ☐Stomach Problems | for dental procedures |
| ☐Autism | ☐Latex Allergy | ☐Neurological Disorder | ☐Thyroid Disease | ☐ Other |
| ☐Bleeding Disorder | ☐Liver Problems | ☐Nervous Disorder | ☐Herpes/Cold Sores | |
| ☐Brain Injury | ☐Lung Problems | ☐Chronic Cough | ☐Heart Murmur | |
| ☐Chemical Dependency | ☐Occupational Therapy | ☐Recurrent Mouth Sores | ☐Mononucleosis | Health History Reviewed |
| ☐Cerebral Palsy | ☐Cleft lip or palate | ☐Celiac Disease | ☐Fainting Spells | (initials date) |
| ☐Down Syndrome | ☐Skin Disorder | ☐Radiation Treatments | ☐Rheumatic Fever | _____ _____ |
| ☐Developmental Delay | ☐Sickle Cell Anemia | ☐Cystic Fibrosis | ☐High Blood Pressure | _____ _____ |

If you answered yes for any question above or for a condition not listed, please explain: _____

_____

What is your water source? ☐ Public System ☐ Private Well ☐ Bottle Water ☐ Filtration System

Is this your child's first dental visit? ☐ Yes ☐ No If no, date of last dental care _____

Prior dentist _____

Child's first dental visit? ☐ Yes ☐ No

Has your child ever had trouble, problems or anxiety with previous dental care? ☐ Yes ☐ No

Has your child ever required an antibiotic prior to dental treatment? ☐ Yes ☐ No

Any specific concerns?