



madisonkidsdentist.com

5544 East Cheryl Parkway • Fitchburg, WI 53711-5312
608-288-1543 • Fax 608-288-0626
7001 Old Sauk Road, Suite 200 • Madison, WI 53717-1010
608-833-6545 • Fax 608-833-8516
5116 American Family Drive • Madison, WI 53718-8331
608-825-7500 • Fax 608-825-0010

About Your Child

Child's Name: _____
Nickname: _____ Female Male
Child's Birthdate: ___/___/___ Age ___
SS#/Ins. ID _____
Does child live with Both Parents Mom Dad Guardian
 Foster Parents Stepmother Stepfather Other
Child's Address: _____
City _____ State ___ Zip _____
If child does not live with both parents please provide addresses
of both parents.
Mom: _____
Dad: _____

Who is Accompanying the Child Today?

Name: _____
Relation to Child: _____
Name of person with legal custody of the child?

Whom may we thank for referring your child?

Other family members seen by us:

Legal Guardian

Mother's/Guardian's Name: _____ DOB ___/___/___
Mother's/Guardians Employer: _____ SS # _____
Telephone Numbers: Home _____ Cell _____ Work _____
E-mail: _____
Father's/Guardian's Name: _____ DOB ___/___/___
Father's/Guardian's Employer: _____ SS # _____
Telephone Numbers: Home _____ Cell _____ Work _____
E-mail: _____

Dental Insurance

Do you have dental insurance? Yes No
Primary insurance co. name, address, phone. Ins. ID # _____

Subscriber for primary insurance is Mom Dad Other
If other is checked provide us with their name, relationship to patient, social security #, employer and birthdate.

Secondary insurance co. name, address, phone. Ins. ID # _____

Subscriber for secondary insurance is Mom Dad Other
If other is checked provide us with their name, relationship to patient, social security #, employer and birthdate.

Do you have Wisconsin Medical Assistance? Yes No
MA ID# _____
If you have WI Medical Assistance, you are required to bring your child's card to each appointment.

Alternate Contact Information (Other than legal guardian)

Name: _____
Relation: _____
Home # _____
Cell # _____
Work # _____

Please Complete Backside

Dental History

Any current dental complaints? _____

Has the child ever had a problem associated with previous dental work? Yes No Specify if yes: _____

Is the child's water fluoridated? Yes No

Is the child taking a fluoride supplement? Yes No If yes, what? _____

Does the child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Is this your child's first dental visit? Yes No

If no, who was the last Dentist? _____ Last visit date: _____

Oral Habits *(please indicate any history)*

Currently using bottle? Y N Y N Thumb/Finger Sucking Specify if yes to any questions

If no, what age discontinued. _____ Y N Nail Biting _____

Currently breastfeeding? Y N Y N Lip Sucking/Biting _____

If no, what age discontinued. _____ Y N Speech Impairment _____

Has the child ever had the following medical problems?

Please indicate any history of the following and write in detail (dates, etc.) below:

Y N ADD/ADHD	Y N HIV+/AIDS	Y N Anemia	Y N Shunts
Y N Heart Murmur	Y N Hemophilia	Y N Congenital Heart Defect	Y N Any stays in a hospital
Y N Cancer	Y N Asthma	Y N Convulsions/Epilepsy	Y N Kidney/Liver Problems
Y N Diabetes	Y N Hepatitis	Y N Abnormal Bleeding	Y N Handicaps/Disabilities
Y N Rheumatic Fever	Y N Tuberculosis	Y N Hearing Impairment	Y N Allergies
Y N Physical or psychological development delay	Y N Any Operations	Y N Other _____	

Please discuss any medical problems the child has had: _____

Child's Physician: _____ Phone #: _____ Last Visit Date: _____

Any current medical complaints? _____

Please list all drugs the child is currently taking: _____

Please list all drugs/latex that the child is allergic to: _____

I understand the information I have given is to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need. I accept full responsibility for full payment of the treatment performed. It is my understanding that two (2) consecutive broken appointments without explanation may lead to dismissal of my child as a clinic patient.

Signature _____ Date _____

Relationship to child _____

FINANCIAL POLICY

Payment is due when services are rendered. We accept cash, personal checks and all major credit cards. We realize that some procedures are more extensive than others and we will be more than willing to work out alternative financial arrangements prior to treatment. I understand and agree that, (regardless of my insurance status or marital status), I am ultimately responsible for the balance on this account for any professional services rendered.

I have read the above information and understand my obligations.

Signature of financially responsible party _____