Dr. Roger Lucas, D.D.S
Lynnwood Kids Dentist
18833-28th Ave W Suite B Lynnwood, WA 98036

Patient Introduction

Please assist us by answering all of the following questions. This confidential information is important for our records in evaluating and treating your child.

Child's Name ______________________________________ Nickname _________________ M □ F □
Child's Birth date _____ / ______/ ______ Age __________ Primary Contact Number _____________________
Child's Home Address ____ City, Zip_________________________
Siblings that we treat ____
Whom may we thank for referring you? ____

Mother's Information
Name ____ Stepmother/Guardian Birth date _____ / ____ / ________
Employer _________________________________ Work # __________________ Home # _____________________
Cell # ______________________ SS # ________________________

Father's Information
Name ____ Stepfather/Guardian Birth date _____ / ____ / ________
Employer _________________________________ Work # __________________ Home # _____________________
Cell # ______________________ SS # ________________________

Marital Status: Married □ Separated □ Widowed □ Divorced □ Single □

Primary Dental Insurance
Name of Insured/Subscriber ____ Birth date ____ / ____ / _______
Relationship to the Patient __________________________________
Insurance Company ____ SS # ___________________________
Employer ____ Insurance Co. Phone # ___________________________
Insurance Co. Address ____
Policy ID #/Member ID _________________________________ Group ID # _______________________________

Secondary Dental Insurance (if applicable)

Name of Insured/Subscriber ____ Birth date ____ / ____ / _______
Relationship to the Patient __________________________________
Insurance Company ____ SS # ___________________________
Employer ____ Insurance Co. Phone # ___________________________
Insurance Co. Address ____
Policy ID #/Member ID _________________________________ Group ID # _______________________________

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY DEPENDENTS.

Financial Responsibility - If parents do not live together, the parent that accompanies the child to the appointment will be responsible for payment at each visit.

SIGNATURE **X** ____ Date __________________

E-Mail ____

Dental History **Patient** ____

Is this your child's first visit to the dentist? ____

-If not, how long since the last visit? ______________________ Were x-rays taken? ________________________

Has your child had an unfavorable experience in a previous dental (medical) office? ___________________________

____

Reason for changing dentists?____

Have there been any injuries to the teeth, face, or mouth? ____

-If yes, please explain ____

Why did you bring your child to the dentist today? ____

Has an Orthodontist seen your child? If so, who? ____

Does your child brush daily? □ Y □ N Floss Daily? □ Y □ N

Does your child receive fluoride vitamins, tablets, water, etc? □ Y □ N ________________________________

Has your child ever had any pain or tenderness in his/her jaw? (TMJ/TMD) □ Y □ N

Child's Habits Does the child have any of the following habits?

Habit	Y	N	
Lip Sucking/Biting	□ Y	□ N	________________
Nail Biting	□ Y	□ N	________________
Grind teeth	□ Y	□ N	________________
Thumb/Finger Sucking	□ Y	□ N	________________
Nursing/Bottle Habits	□ Y	□ N	________________

Medical History Has the child ever had any of the following conditions?

Condition	Y	N	Condition	Y	N
Asthma	Y □	N □	Liver Disorder	Y □	N □
Cancer	Y □	N □	Kidney Disorder	Y □	N □
Hepatitis	Y □	N □	Gastrointestinal Disorder	Y □	N □
Hemophilia/Blood Disorder	Y □	N □	Diabetes	Y □	N □
Rheumatic Fever	Y □	N □	Congenital Heart Defect	Y □	N □
Epilepsy/Convulsions	Y □	N □	Anemia	Y □	N □
Tuberculosis	Y □	N □	ADD/ADHD	Y □	N □
HIV/AIDS	Y □	N □	Pregnancy	Y □	N □
Hearing Impairment	Y □	N □	Disabilities	Y □	N □
Autism	Y □	N □	Latex Allergy	Y □	N □

Please describe any medical problems that your child has: ____

____

Has your child ever been hospitalized or had surgery? ____

____

Is the child currently under the care of a physician? Y □ N□ ____________________________________

Is your child currently taking any medications? ____

____

Please list your child's **allergies** to any medication or food: _______________________________________

____

Child's Physician ___________________________________ **Phone** ___________________________

I certify that I have read and understand the above information. The above questions have been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payers and/or health practitioners. I also authorize the dental staff to perform the necessary dental service my child may need.

Signature X ________________________________ Relationship to Child ________________ Date __________