

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 _____ Stepmother/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?

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?

- | | | | | | |
|---------------------------|----------------------------|----------------------------|---------------------------|----------------------------|----------------------------|
| Asthma | Y <input type="checkbox"/> | N <input type="checkbox"/> | Liver Disorder | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| Cancer | Y <input type="checkbox"/> | N <input type="checkbox"/> | Kidney Disorder | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| Hepatitis | Y <input type="checkbox"/> | N <input type="checkbox"/> | Gastrointestinal Disorder | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| Hemophilia/Blood Disorder | Y <input type="checkbox"/> | N <input type="checkbox"/> | Diabetes | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| Rheumatic Fever | Y <input type="checkbox"/> | N <input type="checkbox"/> | Congenital Heart Defect | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| Epilepsy/Convulsions | Y <input type="checkbox"/> | N <input type="checkbox"/> | Anemia | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| Tuberculosis | Y <input type="checkbox"/> | N <input type="checkbox"/> | ADD/ADHD | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| HIV/AIDS | Y <input type="checkbox"/> | N <input type="checkbox"/> | Pregnancy | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| Hearing Impairment | Y <input type="checkbox"/> | N <input type="checkbox"/> | Disabilities | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| Autism | Y <input type="checkbox"/> | N <input type="checkbox"/> | Latex Allergy | Y <input type="checkbox"/> | N <input type="checkbox"/> |

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** _____