Welcome to Star Kids!

At Star Kids Pediatric Dentistry We Are Committed To Providing Quality Dental Care To Create A Safe, Fun And Comfortable Dental Experience For Your Child.

Your Child ___________________Social Security # _______-_______-_______

Name ___________________________________ Nickname __________________ Date of Birth ________________ Age_____

Male_____ Female_____ What language does your child prefer? _______________ Child Lives With: ______________________

Father ___ Stepfather ____ Guardian ____ (Must provide proof of guardianship) Custodial Parent? ____Yes ____ No

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

Name ____ **email** ____

Address ____________________________________ City __________________State ______ Zip__________

Date of Birth ___________________Social Security # _______-_______-_______ Driver's License # _____________________

Home Phone #__________________________ Cell # ___________________________ Work Phone # _____________________

Employer ____ Occupation ____

☐ Check this box if you DO NOT want to receive email or Text communications from Star Kids Pediatric Dentistry.

Mother ___ Stepmother ____ Guardian ___ (Must provide proof of guardianship) Custodial Parent? ____Yes ____ No

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

Name ____ **email** ____

Address ____________________________________ City __________________State ______ Zip__________

Date of Birth ___________________Social Security # _______-_______-_______ Driver's License # _____________________

Home Phone #__________________________ Cell # ___________________________ Work Phone # _____________________

Employer ____ Occupation ____

☐ Check this box if you DO NOT want to receive email or Text communications from Star Kids Pediatric Dentistry.

Whom may we contact if you cannot be reached or in case of emergency?

Name: ____________________________________ **Phone #**_____________________ **Relation** ____________________________

Who referred you to our office? ____

Primary Dental Insurance: TX Medicaid ___ TXCHIP ___ NM Medicaid ___Other ______________________

Insured's Name _______________________________________ Relationship to patient __________________________________

Date of Birth ________________________ Social Security # _________-________-_________

Is there secondary Dental Insurance coverage? No _____ Yes ____

Primary Medical Insurance: TX Medicaid ___ TX CHIP ___ NM Medicaid ___Other ______________________

Insured's Name _______________________________________ Relationship to patient __________________________________

Date of Birth ________________________ Social Security # _________-________-_________

Is there secondary Medical Insurance coverage? No ___ Yes ____

Payment is required in full at each appointment. For your convenience, we accept:

-Cash -Personal Checks -Debit/Credit Cards -Care Credit

Medical Questionnaire   Patient's Name: ____________________________ DOB: __________________

Child's Physician ____ Phone #______________________

Child's Specialist ____ Phone #______________________

Has your child been hospitalized? ___ No___ Yes, explain ______________________________

Have you ever been told your child has a heart murmur? ___ No___ Yes, explain ______________________________

Is your child currently being treated by a physician? ___ No ___ Yes, explain ______________________________

Does your child have any allergies? ___ No ___ Yes, explain ______________________________

Has your child ever experienced an unfavorable reaction to medications, antibiotics, or local anesthesia? ___No ___Yes

Explain____

Has your child ever undergone general anesthesia? ___ No ___Yes, explain ______________________________

Has your child or anyone in your family had problems with general anesthesia? ___No___ Yes, explain ____________________

Is your child currently taking any medications? ___No __Yes, List them ______________________________

Does your child have a history of developmental or behavioral problems? ___No ___Yes, explain ____________________

What is your child's intellectual level? ___Above Average ___Average ___Below Average ___Learning Disabled ____School grade

Is your daughter pregnant ____Yes ____No ___N/A

Has or does your child have a history or difficulty with any of the following?

___AIDS	___Bleeding Disorder	___Cleft Palate/Lip	___Heart Condition	___Seizures/Epilepsy
___ADD/ADHD	___Cancer/Malignancies	___Diabetes	___Kidneys	___Thyroid
___Asthma	___Cerebral Palsy	___Down Syndrome	___Liver/Hepatitis	___Tuberculosis
___Autism	___Chronic Sinus	___Ears/Hearing	___Rheumatic Fever	

Other: ____

Dental Questionnaire

Last visit to the dentist: Date_________________ Dentist________________________ Services Rendered____________________

Does your child have dental complaints? ___No ___Yes, Explain____

Any injuries to the teeth, mouth or head? ___No ___Yes, Explain____

Does your child have any of the following?

___Pain	___Swelling	___TMJ/Joint Problems		___Bruxism (Grinding)	___Headaches	
___Bottle	___Nursing	___Pacifier	___Thumb Sucking	___Finger Sucking	___Lip Biting	___Nail Biting

Does your child brush daily? ___No ___Yes Does your child floss? ___No ___Yes

Is Fluoride taken in any form? ___No ___Yes, In what form? ______________________________________

What is your child's attitude towards dentistry? ____

Do you desire complete dental service for your child? ____Yes ____ No, explain______________________________

Authorization and Acknowledgement

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services my child may need.

____ I authorize my child's Physician, Specialist and/or previous Dentist listed above, to release any information or records necessary to Star Kids Pediatric Dentistry in the course of treatment to my child .

____ I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I have been advised and understand that I am responsible for any balance on my account.

____ I agree that all medical records and x-rays taken in this office or by any other facility, whether or not paid for by the undersigned, shall become a part of the doctor's professional records and shall be subject solely to his control and disposition.

____ I authorize the doctors to use photographs, radiographs, other diagnostic aids and treatment records for the purposes of teaching, research and scientific publications.

____ ________________ ______________________________

Signature of Parent or Guardian   Date   Witness