Welcome to Little Smiles

Jennifer L. Kiening DDS, PA
Diplomate American Board of Pediatric Dentistry

ABOUT YOUR CHILD:

Name: _____
Nickname: _____Male: ____Female: ____
Date of Birth: _____
Home Address: _____
_____
Home Phone: _____

School: _____Grade:_____
Hobbies, Interests: _____

Brother(s)? _____Age(s) _____
Sister(s)? _____Age(s) _____

Please provide us with your current Email Address:
_____

ABOUT YOUR FAMILY:

Father's Information:
□Married □Single □Guardian □Step Father □Foster Parent
Name: _____
S.S.#_____Drivers License #_____
Date of Birth: _____
Employer: _____Occupation: _____
Work Phone: _____Cell: _____

Mother's Information:
□Married □Single □Guardian □Step Father □Foster Parent
Name: _____
S.S.#_____Drivers License #_____
Date of Birth: _____
Employer: _____Occupation: _____
Work Phone: _____Cell: _____

Who is the Primary Guardian for your Child?
_____

DENTAL HISTORY:

What is the reason for today's visit? _____

Is this your child's first dental visit?_____If NO, what was the date of his/her last dental visit?_____
What was the Dentist's Name? _____
Was there a previous unfavorable medical/dental experience? _____
If so, please explain: _____
Does your child have any of the following?
□**Dental Pain** □**Swelling** □**Cavities** □**Sores in Mouth** □**Sealants** □**Fillings** □**Injured Teeth** □**Extracted Teeth**
At what age was bottle or breast feeding stopped? _____

How will you predict your child will behave? □**Cooperative** □**Fearful** □**Defiant** □**Don't Know**

Does your child have any of the following habits?

□Pacifier use
□Thumb Sucking
□Nursing
□Mouth breathing
□Lip Sucking/Biting
□Nail Biting
□Finger Sucking
□Bottle use
□Grinding

Referral Information:

Whom may we thank for referring you to our practice?
□Google □Drive By □School □Work
□Doctor/Dental Office _____
□ Neighborhood Newsletter _____
□ Another Patient_____
□Other _____

DENTAL INSURANCE:

Insurance Company: _____
Policy Holder: _____
Employer: _____
D.O.B: _____
SS#: _____
ID Number: _____**Group#**_____
Relationship to Patient: _____

For our patients with dental insurance, we will be happy to file insurance claims for you as long as your insurance can be verified. We ask you to pay all non-covered fees as treatment progresses.

_____
Signature of Parent/Guardian **Date**