



Welcome to Little Smiles

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ABOUT YOUR CHILD:

Name: _____
(FIRST) (M) (LAST)

Nickname _____ Male Female

Date of Birth: _____

Social Security #: _____

Home Address: _____

(Apt #) (City) (State) (Zip)

Email Address: _____

Home Phone: _____

School: _____

Grade: _____

Child's Hobbies, favorite games: _____

Brothers? _____ Age(s): _____

Sisters? _____ Age(s): _____

ABOUT YOUR FAMILY:

Father's Information:

Married Single Guardian Step Father Foster Parent

Name: _____

Social Security #: _____

Date of Birth: _____

Employer: _____ Work Phone: _____

Occupation: _____

Home Phone: _____ Cell Phone: _____

Drivers License#: _____ Exp: _____

Mother's Information:

Married Single Guardian Step Mother Foster Parent

Name: _____

Social Security #: _____

Date of Birth: _____

Employer: _____ Work Phone: _____

Occupation: _____

Home Phone: _____ Cell Phone: _____

Drivers License#: _____ Exp: _____

Who is the primary guardian of your child? _____

DENTAL HISTORY:

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

If no, what was the approximate date of last dental visit? _____ What was the name of the dentist? _____

Was there a previous unfavorable medical/dental experience? Yes No

If so, please explain: _____

Does your child receive fluoride? Yes No If so, which type? Tablets Drops Vitamins Rinse

Is your home supplied with well water or city water?

Does your child brush his or her teeth twice daily? Yes No Do you assist them? Yes No

At what age was bottle or breast feeding stopped? _____

Does your child have any of the following?

- Dental Pain Swelling Cavities Sores in Mouth
- Sealants Fillings Injured Teeth Extracted Teeth "Crooked Teeth"

How do you predict your child will behave? Cooperative Fearful Defiant Don't know

What is the reason for today's visit? _____

Does your child have any of the following habits?

- Pacifier use
- Thumb/finger sucking
- Lip sucking/biting
- Nail biting
- Nursing/bottle habits
- Mouth breathing
- Nighttime grinding of teeth

REFERRAL INFORMATION:

Whom may we thank for referring you to our practice?

- Google Drive By School Work
- Doctor's Office _____ Dental Office _____
- Neighborhood Newsletter _____
- Another Patient _____ Other _____

DENTAL INSURANCE:

Dental Insurance Co. _____

Insurance Co. Phone #: _____

Group#: _____

Insured's Name: _____

Insured's DOB: _____

Insured's SSN: _____

Insured's ID #: _____

Relationship to Patient: _____

Employer: _____

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 _____