Joseph G. Baba D.D.S.

TMJ & SLEEP THERAPY CENTRE OF KANSAS

Craniofacial Pain • Headaches • TMJ Disorders
Obstructive Sleep Apnea • Dentofacial Orthodontics

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational.

1 TELL US ABOUT YOUR CHILD

Today's Date: ____________________

Child's Name: ______________________________
LAST FIRST MI

Nickname: ______________________________ ❑ Male ❑ Female

Child's Birthdate: ________________ Child's Age: ____________

School: ____________________ Grade: ______________

Child's Home #: ____________________ SS#: ____________

Child's Home Address:

______________________________ APT/CONDO#

____
CITY STATE ZIP

2 WHO IS ACCOMPANYING THE CHILD TODAY?

Name: ____________________ Relation: ______________

Do you have legal custody of this child? ❑ Yes ❑ No

Whom may we thank for referring you? ____________________

Other family members seen by us: ____________________

____

Previous / Present Dentist: ____________________
(PLEASE CIRCLE)
Last Visit Date: ____________________

Parent's Marital Status ❑ Single ❑ Widowed ❑ Married ❑ Divorced ❑ Separated

3 MOTHER'S INFORMATION (❑ Step Mother ❑ Guardian)

Name: ______________________________

Work #: ______________ Ext: _____ HM #: ____________

Employer: ______________________________

SS# : ______________ email: ______________

FATHER'S INFORMATION (❑ Step Father ❑ Guardian)

Name: ______________________________

Work #: ______________ Ext: _____ HM #: ____________

Employer: ______________________________

SS# : ______________ email: ______________

4 PERSON RESPONSIBLE FOR ACCOUNT

Name: ____________________ Relation: ______________

Billing Address: ______________________________

____
CITY STATE ZIP

Work #: ______________ Ext _____ HM #: ____________

EMPLOYER: ______________________________

SS #: ____________________ DL #: ______________

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name: ______________________________

Work: ______________ Ext: _____ HM: ____________

5 Primary Dental Insurance

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Group # (Plan, Local or Policy #): ____________________

Insured's Name: ______________ Relation: ____________

Insured's Birthday: ____________ Insured's SS #: ____________

Insured's Employer ______________________________

Orthodontic Coverage? ❑ Yes ❑ No

Secondary Dental Insurance

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Group # (Plan, Local or Policy #): ____________________

Insured's Name: ______________ Relation: ____________

Insured's Birthday: ____________ Insured's SS #: ____________

Insured's Employer ______________________________

Orthodontic Coverage? ❑ Yes ❑ No

6 WHY DID YOU BRING THE CHILD TO THE DENTIST TODAY? ____________________

____

Has the child ever had a serious / difficult problem associated with previous dental work? ❑ Yes ❑ No

Is the child taking fluoridated supplements? ❑ Yes ❑ No

Has the child ever had any pain / tenderness in the jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Child's Physician: ____________________

Phone #: ____________________ Date of Last Visit: __________

Is the child currently under the care of a physician? ❑ Yes ❑ No

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking: ____________________

____

____

Please list all drugs that the child is allergic to: ____________________

____

____

7 HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Heart Murmur
Y N Cancer
Y N Diabetes
Y N Rheumatic Fever
Y N HIV+ / AIDS
Y N Hemophilia
Y N Asthma
Y N Hepatitis
Y N Tuberculosis (TB)
Y N Congenital Heart Defect
Y N Convulsions / Epilepsy
Y N Abnormal Bleeding
Y N Hearing Impairment
Y N Any Operations
Y N Any stays in a hospital
Y N Kidney / Liver problems
Y N Handicaps / Disabilities
Y N Allergies to any drugs
Y N Seasonal Allergies

Please list any serious medical condition(s) that the child has had:

____

____

8 DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

Y N Difficulty Breathing Through Nose
Y N Thumb / Finger Sucking
Y N Lip Sucking / Biting
Y N Nail Biting
Y N Clench / Grind
Y N Snore, Stop Breathing
Y N Nite Terrors
Y N Currently wets the bed

Infection control mandated by OSHA.

9

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

____
SIGNATURE OF PARENT OR GUARDIAN DATE

The Parent or Guardian who accompanies the child is responsible for payment at time of services unless prior arrangements have been made.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / Guardian & patient named herein.

Initials ____________________ Date ____________________

Doctor's Comments: ____________________

____

____

MEDICAL HISTORY UPDATE

1. Date __________ Signature: ____________________

Billing Address: ____________________

____

2. Date __________ Signature: ____________________

Billing Address: ____________________

____

I here by authorize payment directly to the below name dentist of the group insurance benefits otherwise payable to me.

SIGNED (Insured Person) ____________________