kids first
DENTAL GROUP

Dr. Laurie Donlan
7314 N. Willowlake Ct. Suite D • Peoria, IL. 61614 • Ph. 309-692-0175

We are pleased to welcome you and your child to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask - we'll be glad to help. We look forward to working with you to maintain your child's dental health.

1

Tell us about your child...

Child's Name: ______________________________ Date of Birth: ____ / ____ / ____
LAST FIRST MI

Age: _____ School: ________________ Grade: ______ ☐ Male ☐ Female Weight: ________

Nickname: ______________ Other family members seen by us: ____________________

Home Address: ______________________CITY______________STATE______ZIP ______

Home Phone#: (____)______________ Email address: ______________________________

Whom may we thank for referring you? ______________________________________

2

Mother's Information: ☐ Mother ☐ Stepmother ☐ Guardian

Name: ______________________________ Date of Birth: ____ / ____ / ____

Home Ph #: (____)__________ Cell Ph #: (____)__________ Work Ph#: (____)__________

Home Address: ____

Employer: ________________ Occupation: ________________ SS#: ________________

Father's Information: ☐ Father ☐ Stepfather ☐ Guardian

Name: ______________________________ Date of Birth: ____ / ____ / ____

Home Ph#: (____)__________ Cell Ph#: (____)__________ Work Ph#: (____)__________

Home Address: ____

Employer: ________________ Occupation: ________________ SS#: ________________

3

Primary Dental Insurance:

Insurance Co. Name: ________________________ Phone #: (____)______________

Insurance Co. Address: ____

Group# (plan/policy#): ____________________ ID/SS#: ________________________

Policy Owner's Name: ______________________ Relation to patient: ______________

Policy Owner's Employer: ________________ Policy Owner's Date of Birth: ____ / ____ / ____

Secondary Dental Insurance (complete ONLY if a second dental policy is present):

Insurance Co. Name: ________________________ Phone #: (____)______________

Insurance Co. Address: ____

Group# (plan/policy#): ____________________ ID/SS#: ________________________

Policy Owner's Name: ______________________ Relation to patient: ______________

Policy Owner's Employer: ________________ Policy Owner's Date of Birth: ____ / ____ / ____

4

Dental History:

Has your child been seen by a dentist before? ☐ Yes ☐ No Dr : ____________________

Date of last visit: ______________ Services performed: ☐ Exam ☐ Cleaning ☐ X-rays ☐ Fluoride ☐ Fillings

Is fluoride taken in any form? ☐ Yes ☐ No

Are you on a well ☐ or do you have reverse osmosis ☐ in your home? Please check, if yes.

Has your child complained of any dental problems? ☐ Yes ☐ No Explain:______________

Has your child sustained injuries to mouth, teeth or head? ☐ Yes ☐ No Explain:______________

____

Any mouth habits? ☐ thumbsucking ☐ nail biting ☐ pacifier ☐ sleeping with bottle ☐ sippy cup past the age of 2 ☐ mouth breathing ☐ Other/explain: ______________________________

Any unfavorable dental experiences? Please explain: ______________________________

Medical History

5

Child's Physician: ______________________ City/State __________________ Phone #: (____)______________

HAS CHILD HAD ANY HISTORY OF/OR DIFFICULTY WITH ANY OF THESE? IF YES, PLEASE CHECK AND EXPLAIN:

☐ ADD	☐ Cancer	☐ Epigastric Reflux	☐ Rheumatic Fever
☐ ADHD	☐ Cerebral Palsy	☐ Epilepsy	☐ Sensory Issues
☐ AIDS/HIV	☐ Convulsions	☐ Fainting	☐ Sinus Problems
☐ Anemia	☐ Developmental Delays	☐ Hearing problems	☐ Other
☐ Asthma	☐ Diabetes	☐ Heart Problems	
☐ Autism	☐ Eating Disorder	☐ Hepatitis	

Explanation: ____

Is the child under the care of a physician now? ☐ Yes ☐ No

Is the child receiving any medication or drugs? ☐ Yes ☐ No --- Please list: ____________________________

Has the child ever been hospitalized? ☐ Yes ☐ No ____

Has the child ever had surgery? ☐ Yes ☐ No

Is there excessive bleeding when cut? ☐ Yes ☐ No

Does the child have any allergies? ☐ Yes ☐ No ------ Please list: ______________________________________

____

Notes/Explanation: ____

Emergency Information:

6

In the event of an emergency, whom should we contact?

Name _________________________________ Relationship ____________________ Phone#: (_____)______________

Name _________________________________ Relationship ____________________ Phone#: (_____)______________

Authorization:

7

I have reviewed the questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment for my child, and I agree to notify the dentist if any changes in my child's health status occur.

I authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submission.

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 behalf of my dependents. I will be responsible for any charges not paid by my insurer within 90 days of my first statement and all expenses which may incur in connection with efforts to collect the charges.

In the event we must enforce our rights under this Agreement after your failure to pay all charges due within 90 days of our first statement, you must pay all charges to include collection agency fees, which are typically 33% to 50% of the unpaid balance, reporter's fees, for depositions and at trial expenses we incur in enforcing our rights under this Agreement. Also, in the event that you have not paid all charges due within 90 days of our first statement, finance charges will begin to accrue at the rate of eighteen percent, 18% per annum. I also agree to release all necessary information in order for the collection agency to reach me. This authorization will remain in effect until revoked by me in writing.

Signature of parent or guardian ____ Date _______________________

Payment is due in full at the time of treatment, unless prior arrangements have been approved.