



Sal Taiym DDS  
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 Telephone 972-396-8080  
 600 E. Bethany Dr. Ste 130  
 Allen, TX 75002

For Office Use Only
Date Rec: _____
Acct #: _____
_____

**Patient Information**

Child's Full Name \_\_\_\_\_ Name Called By \_\_\_\_\_  
 Age \_\_\_\_\_ Birthday \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_ Place of Birth \_\_\_\_\_  
 Child's Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Hm Phone ( ) \_\_\_\_\_

Child's Favorite Hobbies/Interests \_\_\_\_\_  
 Name of School/Day Care \_\_\_\_\_  
 Brothers (Names & Ages) \_\_\_\_\_  
 Sisters (Names & Ages) \_\_\_\_\_  
 Child's Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Address \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

What is your Child's Current Weight? \_\_\_\_\_ What is your Child's Current Height? \_\_\_\_\_

**Parent/Guardian Information**

Parent/Guardian Name \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work/Mobile Phone ( ) \_\_\_\_\_  
 Parent/Guardian Name \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work/Mobile Phone ( ) \_\_\_\_\_

Email Address \_\_\_\_\_

How did you find out about our office? \_\_\_\_\_

**Emergency Contact-Friend or Relative Not Living with You**

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Address \_\_\_\_\_ Zip Code \_\_\_\_\_

**Insurance Information**

Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Insured's Date of Birth \_\_\_\_\_ Insured's Employer \_\_\_\_\_  
 Name of Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

I have received the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental plan benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or portion of such charges. To the extent permitted by law, I authorize release of any information relating to claims filed.

\_\_\_\_\_  
 Signature of Insured Date \_\_\_\_\_

I hereby authorize payment of the dental benefits otherwise payable to me directly to Allen Kids Dentistry, PLLC.

\_\_\_\_\_  
 Signature of Insured Date \_\_\_\_\_

## MEDICAL HISTORY

Please indicate with a **YES** or **NO**. Does your child currently have/preciously had any of the following health problems?

\_\_\_\_\_ **Allergies (Food, Dust, Drug, Unknown)**

If yes, Please List \_\_\_\_\_

\_\_\_\_\_ **Rheumatic Fever / Rheumatic Heart Disease**

\_\_\_\_\_ **Congenital Heart Disease or Heart Murmur**

If yes, Premed Needed? \_\_\_\_\_

Name of Pharmacy: \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

\_\_\_\_\_ **Asthma or Hay Fever (Please Indicate)**

If yes, please list any current medications: \_\_\_\_\_

\_\_\_\_\_ **Arthritis or Rheumatism (painful, swollen joints)**

\_\_\_\_\_ **Convulsions, Seizures, Fainting, or Epilepsy**

\_\_\_\_\_ **Anemia or Blood Disorders**

\_\_\_\_\_ **Speech, Learning, or Hearing Disorders**

Are your child's Immunizations Current? \_\_\_\_\_

Please explain any other medical concerns/Current Medication(s): \_\_\_\_\_

\_\_\_\_\_

## DENTAL HISTORY

Date of Last Dental Visit \_\_\_\_\_ By Dr. \_\_\_\_\_

Do you have any Current Records (including x-rays) from another practice? **Yes** **No**

Has your child complained about any dental problems? \_\_\_\_\_

Any injuries or surgeries to mouth, teeth, head? **Yes** **No** If yes, please describe \_\_\_\_\_

Does your child still take the bottle or sippy cup? \_\_\_\_\_

Does your child brush daily? **Yes** **No** How Often? \_\_\_\_\_

Do you assist your child w/Brushing? **Yes** **No** How Often? \_\_\_\_\_

Is Dental Floss used? **Yes** **No**

Please indicate with a **YES** or **NO**. Does your child have any of the following Mouth Habits

\_\_\_\_\_ Thumb Sucking \_\_\_\_\_ Mouth Breathing \_\_\_\_\_ Pacifier \_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Nail Biting \_\_\_\_\_ Finger Sucking \_\_\_\_\_ Grinding \_\_\_\_\_

How does your child receive Fluoride?

- Water Supply  Toothpaste  Tablets  Other \_\_\_\_\_  
 Dentist  Vitamins  None \_\_\_\_\_

Child's Attitude Towards Dentistry: \_\_\_\_\_

Reason for Today's Visit/Chief Concerns: \_\_\_\_\_

\_\_\_\_\_

I hereby certify that all of the above information is correct and true. Because the above-named child is a minor, it is necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. Furthermore, I will be responsible for any professional fees incurred for dental services for my child. I understand that I am responsible for all charges whether or not covered by insurance. All balances over 30 days are subject to a 1.5% per month **finance charge**.

Signed \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_