DRS. KEARNS, ASHBY, RAJCHEL & ASSOCIATES
DENTISTRY FOR INFANTS, CHILDREN & TEENS

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New Patient Pre-Appointment Check-List

Welcome to our practice. We want to make sure your first visit to our office is an exceptional one. To help us meet your expectations please use this check-list to make sure we have all of the information we will need for your visit.

- Contact your previous dentist and ask them to send your records to the office where your child is scheduled to be seen:

  Mechanicsburg office - kidsdentaloffice@comcast.net
  Harrisburg office - eskidsdentaloffice@comcast.net

- Complete the new patient health history form **before you arrive** and **bring it with you to the appointment.**
- **Arrive 15 minutes before** your scheduled time to complete additional paperwork.
- Bring your insurance card if one was issued.
- Please be sure you have the following information for the person who carries the insurance for the child. If you do not have the needed insurance information at the time of your appointment, we will expect payment at the time of service.
  - Insured's Name, Address & Phone number
  - Insured's Date of Birth
  - Insured's Plan, Member ID# or SSN
  - Insured's Group Number
  - Insured's Employer

- For families that do not have dental insurance coverage, payment is expected at the time of service. For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover or Care Credit.
- A parent and/or legal guardian **must** accompany the child to their initial visit.

We look forward to meeting you!

Drs. Kearns, Ashby, Rajchel and Staff

Welcome

Drs. Kearns, Ashby, Rajchel & Associates

Dr. Dwight Ashby Dr. Nancy Rajchel
Dr. Jeffrey Kearns

HEALTH HISTORY FORM

PATIENT ACCOUNT NUMBER ________________

1. Tell Us About Your Child

Child's Name ____

Goes By: ____________________ ☐ Male ☐ Female

Name & Ages of Siblings ______________________________

____

Child's Birthday _____/_____/_____ Child's Age ___________

School ________________________ Grade ___________

SS# ____

Reason For Visit ____________________________________

____

____

Mother's Information

Name ____

Mother Stepmother Guardian Birthdate _____/_____/_____

Marital Status: ______________________________________

Employer: ____

Work # ________________________ Ext. ____________

Home/Cellular Phone #'s ______________/______________

SS#____

Home Address____

____

Father's Information

Name ____

Father Stepfather Guardian Birthdate _____/_____/_____

Marital Status: ______________________________________

Employer: ____

Work # ________________________ Ext. ____________

Home/Cellular Phone #'s ______________/______________

SS#____

Home Address____

____

4. We confirm appointments by text and email.

Cell phone number to **text** to ______________________________

Email address ____

Who May We Thank For Referring You To Our Office?

____

6. With Whom Does Your Child Reside?

____

Primary Dental Insurance

Insurance Company Name ______________________________

Insurance Co. Address ________________________________

____

Insurance Co. Phone # ________________________________

Group # ____________________ ID# __________________

Policy Owners Name __________________________________

Relationship to Patient ________________________________

Policy Owner's Birthday ____/____/____ SS# ______________

Policy Owner's Employer ______________________________

Secondary Dental Insurance

Insurance Company Name ______________________________

Insurance Co. Address ________________________________

____

Insurance Co. Phone #________________________________

Group # ____________________ ID# __________________

Policy Owners Name __________________________________

Relationship to Patient ________________________________

Policy Owner's Birthday ____/____/____ SS# ______________

Policy Owner's Employer ______________________________

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

9. Dental History

Is this your child's first visit to the dentist?_____________________

If not, how long since the last visit to the dentist? _______________

Previous Dentist's Name & Number__________________________

____

Were any x-rays taken at previous dentist? ___________________

Have there been any injuries to the teeth, face or mouth?________

If yes, please explain ______________________________________

____

How do you expect your child to act at this visit? _______________

____

Does the child have any of the following habits? (Please circle)

Lip Sucking/Biting	Nail Biting	Thumb/Finger Sucking
Grind Teeth	Clench Jaws	Nursing/Bottle Habits

Has the child ever had a serious or difficult problem associated with previous dental work? _______________________________

____

Is the child's water fluoridated?	Yes	No
Is the child taking fluoride supplements?	Yes	No
Does the child brush his/her teeth daily?	Yes	No
Does the child floss daily?	Yes	No

10. Health History

Has the child ever had any of the following conditions (Please circle)

Abnormal bleeding	Convulsions/Epilepsy	Hepatitis
Allergy to Dyes	Developmental Delay	HIV/AIDS
Allergy to Latex	Diabetes	Kidney/Liver Disease
Asthma	Handicaps/Disabilities	Pacemaker
Autism	Hearing/Speech Impaired	Respiratory Disease
Bleeding Disorder	Heart Disease	Rheumatic Fever
Cancer	Heart Murmur	Thyroid Disease
Cerebral Palsy	Hemophilia/Blood Disorders	Tuberculosis

If no conditions above are circled please initial here ___________________

If heart murmur was circled, does the child require premedication? ______

Please discuss any other medical conditions/surgeries/hospital stays the child has had

____

____

Please list all medications the child is currently taking __________________

____

Please list the child's allergies including medications, latex, dyes, etc. ______

____

Child's Physician __________________________Number _______________

Child's Cardiologist ________________________Number _______________

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

If yes, please explain____

☐ I understand that the information 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 acknowledge that I have been given a copy of the office's Notice of Privacy Practice. I authorize the dental staff to perform the necessary dental services my child may need. This consent shall remain in effect until cancelled by the parent or guardian. I agree to be responsible for the payment of all rendered treatment on behalf of my dependents.

____ ____________________________________

Signature of Parent or Guardian Date Relationship to Patient

Medical History Update

Date ________ Comments ____________________________ Date ________ Comments ____________________________

____ ____

Parent's Signature ___________________________________ Parent's Signature ___________________________________

Date ________ Comments ____________________________ Date ________ Comments ____________________________

____ ____

Parent's Signature ___________________________________ Parent's Signature ___________________________________

Date ________ Comments ____________________________ Date ________ Comments ____________________________

____ ____

Parent's Signature ___________________________________ Parent's Signature ___________________________________