



KEARNS & ASHBY D.D.S., P.C.

Patient I.D. _____

(Office use only)

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Child's Name _____ Birthdate _____

Nickname _____ Sex _____ Age _____ Grade _____

Names and ages of siblings _____

Home Address _____

City, State, Zip _____ Home/Cell Phone _____

School _____ Child's S.S.N. _____

Reason for this visit _____

Who Is Responsible for Making Appointments? _____

Daytime Phone Number to Confirm/Schedule Appointments _____

Email Address _____

Who may we thank for referring you to our office? _____

PARENT OR GUARDIAN INFORMATION

Father ___ Stepfather ___ Guardian ___ Full Name _____

Address _____ Home Phone/Cell Phone _____

City, State, Zip _____ SSN _____ DOB _____

Employer _____ Work Phone _____ Ext. _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

Mother ___ Stepmother ___ Guardian ___ Full Name _____

Address _____ Home Phone/Cell Phone _____

City, State, Zip _____ SSN _____ DOB _____

Employer _____ Work Phone _____ Ext. _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

With whom does the child currently reside? _____

Primary Dental Insurance

Subscriber's Name _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Home Phone _____

Home Address _____

Employer _____ Work Phone _____ Ext. _____

Insurance Co. _____ Ins. Co Phone # _____

Insurance Co. Address _____

Group Number _____ I. D. Number _____

Secondary Dental Insurance

Subscriber's Name _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Home Phone _____

Home Address _____

Employer _____ Work Phone _____ Ext. _____

Insurance Co. _____ Ins. Co Phone # _____

Insurance Co. Address _____

Group Number _____ I. D. Number _____

*****PLEASE COMPLETE THE MEDICAL INFORMATION SECTION ON THE BACK OF THIS FORM*****

Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications that your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____ Floss? _____

Is your child's water fluoridated? Yes ___ No ___

Does your child take fluoride supplements? Yes ___ No ___

Does your child:

Suck Thumb/Finger Yes ___ No ___ Chew Hard Objects Yes ___ No ___

Suck/Bite Lip Yes ___ No ___ Grind Teeth Yes ___ No ___

Bite/Chew Nails Yes ___ No ___ Clench Jaws Yes ___ No ___

Date of last dental visit _____ Previous dentist _____

Address _____ Phone Number _____

Has your child had difficulty with previous dental visits? Yes ___ No ___

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

Child's Physician _____ Phone Number _____

Child's Cardiologist _____ Phone Number _____

Please list and date any previous hospitalizations/surgeries/serious illnesses:

Is your child under the care of a physician? Yes ___ No ___ (If yes, please explain) _____

Is your child taking any medications? Yes ___ No ___ (If yes, please list) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any medications (Penicillin, Novocain, etc.)?

Yes ___ No ___ If yes, please describe _____

Does your child have a history of allergies to any other substances (latex, environmental, dyes, etc.)?

Yes ___ No ___ If yes, please describe _____

Has your child ever had any of the following:

Latex Allergy Yes ___ No ___ Liver Disease Yes ___ No ___

Rheumatic Fever Yes ___ No ___ Kidney Disease Yes ___ No ___

Heart Disease Yes ___ No ___ Bladder Disease Yes ___ No ___

Heart Murmur Yes ___ No ___ Respiratory Disease Yes ___ No ___

If yes, is premedication required? Yes ___ No ___ Sickle Cell Disease/Trait Yes ___ No ___

Pacemaker Yes ___ No ___ Thyroid Disease Yes ___ No ___

HIV/AIDS Yes ___ No ___ Developmental Delay Yes ___ No ___

Hepatitis Yes ___ No ___ Hearing-Impaired Yes ___ No ___

Anemia Yes ___ No ___ Speech Impaired Yes ___ No ___

Diabetes Yes ___ No ___ Cancer Yes ___ No ___

Tuberculosis Yes ___ No ___ Epilepsy Yes ___ No ___

Asthma Yes ___ No ___ Mental Retardation Yes ___ No ___

Cerebral Palsy Yes ___ No ___ Autism Yes ___ No ___

Please explain any medical problems that your child has not listed above:

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental 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. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/to other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient/Parent/Guardian _____

Date _____