About the Patient

Name: ______________________________

Nickname: __________________________

Birthdate: ___________________________

Male: _____ Female: _____ Age: ______

Patient's address:

____

____

Patient's email: ______________________________

Special interests/hobbies:

____

School & Grade:

____

With whom does the patient live:

____

Sibling's names and ages:

____

____

What is your primary concern about your child's oral health? ______________________________________

____

Is this your child's first dental visit? Yes ☐ No ☐

If, no who was your previous dentist:

____

Date of last visit? ______________________________

X-rays taken? Yes ☐ No ☐

Recent trauma to the face/mouth? Yes ☐ No ☐

Father: ______________________________________

Date of birth: __________________________________

Phone number: work/cell/home

____

Email: _______________________________________

Mother: ______________________________________

Date of birth: ______________________

Phone number: work/cell/home

____

Email: _______________________________________

City Water: _____ Well Water: _____

Takes Fluoride? Yes ☐ No ☐

If, yes: Drops ☐ Tabs ☐

Takes Supplements? Yes ☐ No ☐

If yes, please specify:

____

At Krause Smiles, providing your child effective and compassionate care is our primary focus. Please read and initial below that you consent to the following:

I give consent to Dr. Krause to obtain x-rays, study models, photographs, or any other diagnostic aids. ______

I give consent to Dr. Krause to provide the appropriate care for my dependents. ______

I understand that payment for services is due at time of service and a 1.5% finance charge will be added to any balance over 30 days. ______

I understand a fee will be charged for any missed appointments. ______

____
Signature Date Relation

For Office Use Only

____

____

____

Medical History

Does your child have a history of any of the following?

Gagging	Yes ☐	No ☐
Mouth sores	Yes ☐	No ☐
Pacifier	Yes ☐	No ☐
Thumb/finger habit	Yes ☐	No ☐
Grinding teeth	Yes ☐	No ☐
Mouth breathing	Yes ☐	No ☐
Impaired hearing/ vision/speech	Yes ☐	No ☐
Recurrent ear problems	Yes ☐	No ☐
Recurrent tonsil & adenoid problems	Yes ☐	No ☐
Clicking or pain opening jaw	Yes ☐	No ☐

Does your child have a history of any of the following?

ADD/ADHD	Yes ☐	No ☐
Anemia	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Bleeding disorder	Yes ☐	No ☐
Cerebral Palsy	Yes ☐	No ☐
Gerd	Yes ☐	No ☐
Autism/spectrum disorder	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Emotional distress	Yes ☐	No ☐
Hepatitis/jaundice	Yes ☐	No ☐
Heart problems	Yes ☐	No ☐
Kidney disorder	Yes ☐	No ☐
Liver disease	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No ☐

Did mom have a healthy pregnancy? Yes ☐ No ☐

Any medications during pregnancy? Yes ☐ No ☐

If yes, please specify: ______________________________

Was the patient jaundice? Yes ☐ No ☐

Was the patient premature? Yes ☐ No ☐

Was the patient breast fed? Yes ☐ No ☐

If yes, how long? ________ Bottle fed how long? ________

Patient's Primary Care Physician:

____

Phone number: ______________________________

Date of last exam: ____________________

Currently taking medication? Yes ☐ No ☐

If yes, please list:

____

Has the patient ever been hospitalized or under general anesthesia? Yes ☐ No ☐

If so, where, when and why?

____

____

Are there any known allergies? Yes ☐ No ☐

If yes, to what? ______________________________

Financial & Insurance Information

Name of subscriber (person financially responsible):

____

Date of birth of subscriber: ______________________________

SSN: ______________________________

Do you have dental insurance? Yes ☐ No ☐

Insurance provider: ______________________________

Group or Subscriber number:

____

Employer: ______________________________

Employer contact info:

560 Riverside Drive, Suite A-205
Salisbury, MD 21801