

# Welcome



**Children's Dental Care of Kenosha**

**Lori J. Kerber, D.D.S.**

**2901 35th Street • Kenosha, WI 53140**

**phone: (262) 658-3488 fax: (262) 658-3433**

## Health History Form

For your convenience... Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

### 1. Tell Us About Your Child

Child's Name \_\_\_\_\_  
Last First MI

Nickname \_\_\_\_\_  Male  Female

Siblings that we treat \_\_\_\_\_

Child's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age \_\_\_\_\_

Child's Home # (\_\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is the child Adopted or a Foster Child? \_\_\_\_\_

Child lives with: Mom Dad Both Joint Custody  
Other (if so whom) \_\_\_\_\_

### 2. Who may we thank for referring you to our office?

\_\_\_\_\_

### 3. Mother's Information

Name \_\_\_\_\_

Mother Stepmother Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ or circle: same as above for child.

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_ DL# \_\_\_\_\_

### 4. Father's Information

Name \_\_\_\_\_

Father Stepmother Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Address if different from address above for the child: \_\_\_\_\_

\_\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_ DL# \_\_\_\_\_

### 5. Who is Accompanying the Child Today?

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

### 6. Person Responsible for Account

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_

Cellular # (\_\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_

### 7. Primary Dental Insurance

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #) \_\_\_\_\_

**Policy Owner's Name** \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Policy Owner's Birthdate** \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_\_

**Policy Owner's Employer** \_\_\_\_\_

### 8. Secondary Dental Insurance

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #) \_\_\_\_\_

**Policy Owner's Name** \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Policy Owner's Birthdate** \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_\_

**Policy Owner's Employer** \_\_\_\_\_

Name: \_\_\_\_\_

**9. Dental History**

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

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

Were any x-rays taken at previous dental visits? \_\_\_\_\_

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

\_\_\_\_\_

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Why did you bring the child to the dentist today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does the child have any of the following habits?

Lip Sucking / Biting        Nail Biting

Nursing / Bottle Habits        Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work?      **Yes**      **No**

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Is the child's water fluoridated?      **Yes**      **No**

Is the child taking fluoride supplements?      **Yes**      **No**

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)?      **Yes**      **No**

Does the child brush his/her teeth daily?      **Yes**      **No**

Floss his / her teeth daily?      **Yes**      **No**

**10. Health History**

Has the child ever had any of the following conditions?

Abnormal Bleeding        Special Needs/Disabilities

Allergies to any Drugs        Hearing Impairment

Any Hospital Stays        Heart Disease/Murmur

Any Operations        Hemophilia/Blood Disorders

Asthma        Hepatitis

Cancer        HIV + / AIDS

Congenital Birth Defects        Kidney/Liver Conditions

Convulsions/Epilepsy        Rheumatic/Scarlet Fever

Pregnancy        Allergies to Latex Product

Tuberculosis        Diabetes

Developmental Delay        Autism

Emotional Disorder        ADD/ADHD

Please discuss any serious medical conditions the child has had \_\_\_\_\_

\_\_\_\_\_

Please list all drugs the child is currently taking \_\_\_\_\_

\_\_\_\_\_

Please list all drugs the child is allergic to \_\_\_\_\_

\_\_\_\_\_

Child's Physician \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

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

Please describe the child's current physical health...

**Good**      **Fair**      **Poor**

Please explain any other special needs the child has: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**11.** 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 authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.**

The parent or guardian who accompanies the child is responsible for the payment of charges.

Signature \_\_\_\_\_

Date \_\_\_\_\_

I agree to be responsible for all charges not paid by my dental insurance and I hereby authorize release of any information relating to this claim to the dental insurance and I also authorize payment of the dental benefits otherwise payable to me directly to the dental entity

Signature \_\_\_\_\_

Date \_\_\_\_\_

**CHILDREN'S DENTAL CARE OF KENOSHA  
WISCONSIN CONSENT FORM**

This form is to obtain an individual's written permission under Wisconsin law for our use and disclosure of the individual's dental care records to carry out treatment, payment activities and health care operations.

**PLEASE READ THE FOLLOWING:**

This consent is a condition of your treatment, by us. If you decide not to sign this consent, we may decline to treat you. **Privacy Practice Notice: You have the right to read out Privacy Practices Notice before you decide whether to sign this consent. Our Notice is posted on the wall, or you may ask the receptionist for a copy.** Our Notice provides a description of our treatment, payment activities and health care operations and of the uses and disclosures we may make of your protected health information. By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities and health care operations as set forth in our Privacy Practices Notice. **Right to Revoke:** This consent is effective until revoked by you. **We may decline to treat you or to continue treating you/ your children, if you revoke this consent. )**

**\*\*\*\*Under 18 Parent signature:** If this consent is signed by a personal representative and or parent **on behalf** of the individual, please sign: **Name** \_\_\_\_\_  
**Relationship** \_\_\_\_\_ **to patient.**

**\*\*\*\*Over 18 Individuals signature**

I, \_\_\_\_\_ have had full opportunity to read and consider the contents of the consent form. I understand that by signing this form I am confirming my written permission for disclosure of my protected health information as described in the form.  
**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

(I give permission for the following people (aunt, uncle, grandparents, friend, etc, to bring my child/children for dental care and treatment and to receive information relating to my children's care. **\*\*I understand that if anyone else brings my children I will send medical updated history with them. If there is no change since last visit, I will note that information. Signature of parent:** \_\_\_\_\_ **date** \_\_\_\_\_

**This is for my child/children:** \_\_\_\_\_  
\_\_\_\_\_ relationship to my child \_\_\_\_\_  
\_\_\_\_\_ relationship to my child \_\_\_\_\_  
\_\_\_\_\_ relationship to my child \_\_\_\_\_

**\*\*I acknowledge that if anyone other than the three above named people brings in the child/ren, I must fax, or mail my permission ahead of the appointment, along with current medical history.**

\*May we leave a Message on your answering machine: **yes** \_\_\_\_\_ **no** \_\_\_\_\_  
**For office use only:** \_\_\_\_\_ individual refused to sign due to: