

**Bellevue Kids Dentist**  
 2150 112th Ave. NE #A  
 Bellevue, WA 98004  
 Ph: 425-455-0784  
 Fax: 425-451-3999



## Welcome

*We are pleased to welcome you and your child to our practice. Please print this page and take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you.*

**PATIENT INFORMATION:**

Child's Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
FIRST MIDDLE LAST

Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Sex:  M  F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ School: \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 Notify in case of emergency (other than parents): \_\_\_\_\_ Phone: \_\_\_\_\_

**PARENTS/GUARDIAN INFORMATION:**

Father/Guardian's Name: _____ Address: _____ _____ Home Phone: _____ Work Phone: _____ Employer: _____ Occupation: _____ SSN: _____ Birthdate: _____ Email: _____ Do you have dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name: _____ Address: _____ _____ Phone: _____ Group #: _____	Mother/Guardian's Name: _____ Address: _____ _____ Home Phone: _____ Work Phone: _____ Employer: _____ Occupation: _____ SSN: _____ Birthdate: _____ Email: _____ Do you have dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name: _____ Address: _____ _____ Phone: _____ Group #: _____
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**DENTAL HISTORY**

What would you like us to do for your child today? \_\_\_\_\_

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Former Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date of last dental care: \_\_\_\_\_ Date of last x-ray: \_\_\_\_\_  
 How often does your child brush? \_\_\_\_\_ Floss? \_\_\_\_\_  
 Does your child experience pain or discomfort in the jaw joint?  Yes  No  
 Has your child experienced a mouth or chin injury?  Yes  No  
 Does your child have speech problems?  Yes  No  
 Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Yes  No  
 Was your child bottle fed?  Yes  No If so, how long? \_\_\_\_\_  
 Is fluoride taken in any form?  Yes  No  
 Other information about your child's dental health or previous treatment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_