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 referrring 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? ❑ Yes ❑ 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? ❑ Yes ❑ No
Plan Name: _____
Address: _____
_____
Phone: _____
Group #: _____

DENTAL HISTORY

What would you like us to do for your child today? _____
_____
Former Dentist: _____ Phone: _____
Address _____
Date of last dental care: _____ Date of last x-ray: _____
How often does your child brush? _____ Floss? _____
Does you 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: _____
_____
_____
_____