Alaska Dentistry for Kids, LLC
Welcomes you

880 'N' Street, Suite 101, Anchorage, AK 99501 907-274-2525

We strive to make each of your child's visits pleasant and comfortable. Our goal is to set a foundation with children which will help them keep their teeth strong and beautiful for their lifetime.

YOUR CHILD

CHILD'S NAME_____ Nickname_____ Sex_____
Birthdate_____ Age____ School? Home___ Private____ Public___ Grade_____
Siblings: Names and ages_____

RESPONSIBLE PARTY

Name_____ Relationship_____
Address_____
City_____ State_____ Zip code_____ Email_____

Mother_____ Stepmother_____ Guardian_____

Name_____ Social Security#/ ID#_____
Home Phone_____ Work Phone_____ Cell_____
Employer_____ Occupation_____

Father_____ Stepfather_____ Guardian_____

Name_____ Social Security#/ID#_____
Home Phone_____ Work Phone_____ Cell_____
Employer_____ Occupation_____

Parent's Marital Status : Single Married Divorced Widowed Separated (please circle)

Primary Dental Insurance

Subscriber's Name_____ Relationship_____ Birthdate_____
Address of Subscriber if different from child's_____
_____
Insurance Company_____ Group #_____

Secondary Coverage

Subscriber's Name_____ Relationship_____ Birthdate_____
Address of Subscriber if different from child's_____
Insurance Company_____ Group #_____

Whom may we thank for referring you to us?_____

Today's date_____ More info on back »»»

MEDICAL HISTORY

*Has your child ever had any of the following: (Check **YES** or **NO**, if Yes, please explain).*

Yes	No	Condition	Explanation
		Is your child taking any medication?	
		Allergies to medicine? If so, please list.	
		Allergies to food? If so, please list.	
		Latex allergy?	
		Does your child have asthma?	
		Immunizations up-to-date?	
		Has your child had c illness in the last month?	
		Has your child been exposed to any infectious illness?	
		Previous hospitalizations or surgeries?	
		Difficulty with anesthesia?	
		Seizures or convulsions?	
		Birth defects?	
		Serious illness?	
		Heart Disease/Murmur/Rheumatic Fever?	
		Diabetes?	
		Does your child require antiobiotic premed prior to dental treatment?	
		Has your child had kidney or bladder problems?	
		Is your child emotionally, physically or mentally challenged?	
		Does your child bruise easily or experience bleeding problems?	
		Fainting spells, dizziness or breath holding spells?	
		Has your child ever been to the dentist before?	
		Has your child had difficulty accepting dental treatment?	
		Is your child taking fluoride supplement or using a topical fluoride?	
		Is your child still nursing?	
		Does your child still take a bottle?	
		Other?	

Child's Physcian_____

Reason for child's visit today_____

Things we should know_____

_____

Is there a family history of:

Yes	No	Condition	Family relationship
		Diabetes	
		Any bleeding problems	
		Neuromuscular problems	
		Trouble with anesthesia	
		Heart disease	
		Other	

AUTHORIZATION

I have reviewed this questionnaire and answered the questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate and safe dental treatment for my child, and I agree to notify the dentist of any changes in my child's health status. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. If at any time you experience a lapse in coverage or there is any portion of your bill upaid by insurance, it remains your full repsponsibility.

I agree to be responsible for payment of all services rendered on behalf of my dependants.

Signature of Parent or Guardian_____ **Date**_____