Lonestar Kid's Dentistry Paul I. Rubin DDS, PA & David Sentelle DMD, PhD, MPH

www.lonestarkidsdds.com ★ (214) 618-5200 ★ Fax (214) 618-5201

Demographic Information

Patient_____ Today's date_____
Patients preferred name_____ Date of Birth_____
Age_____ Sex_____ Cell Phone_____

Whom may we thank for referring you to our practice? _____
Which office location would you prefer to be seen at? ☐ **Frisco** ☐ **McKinney**

Home Address_____
Street City Zip code
School_____ Grade_____
Mother_____ Email/Phone_____
Mother's Employer_____ Work Phone_____
Father_____ Email/Phone_____
Father's Employer_____ Work Phone_____
Who has legal custody of child? _____
Person responsible for payment of account _____
Dental Insurance Carrier_____ Insurance phone # _____
Mother's DOB_____ Mother's SS#/Ins ID#_____
Father's DOB_____ Father's SS#/Ins ID#_____

Health History

☐ Yes ☐ No Is your child in good health? Name of child's physician_____
Phone_____ Date of last medical checkup_____
☐ Yes ☐ No Has your child ever had any health problems? _____
☐ Yes ☐ No Has your child ever been hospitalized? If so, list why and date_____
_____
☐ Yes ☐ No Is your child allergic to anything (food/drugs/dye/latex, etc.)?_____
_____
☐ Yes ☐ No Is your child currently taking any medication (including OTC)? If so, please list with the dosage _____
☐ Yes ☐ No Were there any problems at birth? _____

Please check if your child has been treated for any of the following:

☐ Anemia	☐ Cancer/Tumors	☐ Heart Disease	☐ Physical Delays	
☐ ADD/ADHD	☐ Congenital Birth Defect	☐ Heart Murmur	☐ Recurrent Headaches	
☐ Asthma	☐ Cleft Lip/Palate	☐ Hepatitis	☐ Rheumatic Fever	
☐ Blood Dyspraxia	☐ Developmental Delay	☐ Kidney Disease	☐ Seizures	
☐ Bleeding/Transfusions	☐ Diabetes	☐ Liver	☐ Speech/ Hearing	
☐ Cerebral Palsy	☐ Frequent Infections	☐ Personality/Social	☐ Sleep Apnea/ Disorder	
☐ Herpes	☐ Tuberculous	☐ HIV	☐ Autism	☐ Other

Please elaborate on ANY items marked:

_____

_____

_____

Do you consider your child to be:

☐ Advanced in the learning process ☐ Progressing normally ☐ Slow in the learning process

Was your child: ☐ Breast fed ☐ Bottle fed At what age was it stopped? _____

Dental History

☐ Yes ☐ No Has your child ever been to the dentist? Name of dentist and care? _____
Explain _____

☐ Yes ☐ No Does your child suck a finger, thumb or pacifier?

☐ Yes ☐ No Does your child have pain with chewing, yawning or wide opening?

☐ Yes ☐ No Does your child's jaw make noise and is pain associated with the sounds?

Please check if your child is having problems with any of the following:

☐ Cavities ☐ Toothache ☐ Teeth Sensitive ☐ Jaw Sounds

☐ Trauma ☐ Gum Infections ☐ Color of Teeth ☐ Orthodontics

☐ Other _____

Fluoride History

☐ Yes ☐ No Is your home water supply fluoridated?

☐ Yes ☐ No Does your child use a fluoride toothpaste?

☐ Yes ☐ No Do you give your child any other form of fluoride? If so, what? _____

☐ Yes ☐ No Does your child participate in a school fluoride rinse program?

Consent for Dental Treatment

I request and authorize Dr. Rubin, Dr. Sentelle, or Dr. Orynich to examine, clean and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Rubin, Dr. Sentelle, or Dr. Orynich to diagnose and/or treat my child's dental health. I will allow photographs to be taken of my child or child's teeth for diagnostic or education purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Rubin, Dr. Sentelle, or Dr. Orynich will provide an environment likely to help learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature of Parent or Legal Guardian_____ **Date:**_____