Terra Pauly D.D.S

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational.

pauly dental

4620 E Douglas, Suite 100
Wichita, KS 67208

Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1. Tell Us About Your Child

Todays Date: _____

Child's Name: _____
Last First MI

Nickname: _____ ❑ Male ❑ Female

Child's Birthdate: _____ Child's Age: _____

School: _____ Grade: _____

Child's Home #: _____ SS# _____

Child Home Address

_____
APT/CONDO#

_____
City StateZip

2. Who is Accompanying the Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Whom may we thank for referring you? _____

Other family members seen by us? _____

_____

Previous / Present Dentist: _____

Last Visit Date: _____

Parent's Marital Status ❑ Single ❑ Widowed ❑ Married ❑ Divorced ❑ Separated

3. Mother's Information (❑ Step Mother ❑ Guardian)

Name: _____

Work #: _____ Ext: ____ HM #: _____

Employer: _____

SS #: _____ Email: _____

Father's Information (❑ Step Father ❑ Guardian)

Name: _____

Work #: _____ Ext: ____ HM #: _____

Employer: _____

SS #: _____ Email: _____

4. Person Responsible for Account

Name: _____

Billing Address: _____

_____

Work #: _____ Ext _____ HM#: _____

Employer: _____

SS #: _____ DL#: _____

Who is Responsible For Making Appointments

Name: _____

Work: _____ Ext: ____ HM# _____

5. Primary Dental Insurance

Insurance Company Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____

Orthodontic Coverage? ❑ Yes ❑ No

Secondary Dental Insurance

Insurance Company Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____

Orthodontic Coverage? ❑ Yes ❑ No

6. Why Did You Bring the Child to the Dentist Today? _____

_____

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

Is the child taking fluoridated supplements? ❑ Yes ❑ No

Has the child ever had any pain / tenderness in their jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Does the child brush their teeth daily? ❑ Yes ❑ No

Floss their teeth daily? ❑ Yes ❑ No

Child's Physician: _____

Phone#: _____ Date of Last Visit: _____

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

Please describe the child's current physical health:
❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking: _____

_____

_____

Please list all drugs that the child is allergic to: _____

_____

_____

7. Has the Child Ever Had Any of the Following Medical Problems?

Y N	Heart Murmur	Y N	Congenital heart Defect
Y N	Cancer	Y N	Convulsions / Epilepsy
Y N	Diabetes	Y N	Abnormal Bleeding
Y N	Rheumatic Fever	Y N	Hearing Impairment
Y N	HIV+ / AIDS	Y N	Any Operations
Y N	Hemophilia	Y N	Any Stays in a Hospital
Y N	Asthma	Y N	Kidney / Liver Problems
Y N	Hepatitis	Y N	Handicaps / Disabilities
Y N	Tuberculosis (TB)	Y N	Allergies to any drugs
		Y N	Seasonal Allergies

Please list any serious medical condition(s) that the child has had:

_____

_____

8. Does the Child Have Any of the Following Habits?

Y N Difficulty Breathing Through Nose
Y N Thumb / Finger Sucking
Y N Lip Sucking / Biting
Y N Nail Biting
Y N Nursing Bottle Habits

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

9.

I understand that the information that 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 also authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of Patient or Guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service
Unless prior arrangements have been made.

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I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials _____ Date _____

Doctor's Comments: _____

_____

_____

Medical History Update

1. Date _____ Signature: _____

Billing Address: _____

_____

2. Date _____ Signature: _____

Billing Address: _____

_____

I hereby authorize payment directly to the below name dentist of the group insurance benefits otherwise payable to me.

SIGNED (Insured Person) _____