Dr. Erin Knierim Pediatric Dentistry
3036 W. Sylvania Ave.~Toledo, OH 43613~419.474.0733

Child's name_____ Nick name_____ Sex M / F

Age_____ Birthday_____/_____/_____ Purpose for visit_____ Family dentist_____

Names and ages of brothers and sisters _____

Give dates of last dental care_____ Where? _____ Were X-rays taken? Yes/No

Child's physician_____ Date of last physical exam_____

Is your child up to date on immunizations? Yes/No Whom may we thank for referring you to us? _____

Please circle and explain all that apply to child _____

Adopted	Allergies	Asthma	Bleeding/Blood Disorder	Blood Transfusion
Cancer/Tumor	Cerebral Palsy	Clenching/Grinding teeth	Congenital Birth Defects	Diabetes
Endocrine disorders	Eye/Sight Problems	HIV/Aids	Hearing Disorder	Heart Disorders
Heart Murmur	Hepatitis	Hospitalizations	Kidney Disorders	Learning Disorders
Liver Disorders	Neurologic disorders	Recurrent Headaches	Rheumatic Fever	Seizures
Thyroid Disorders				

Has your child had any unfavorable reaction to drugs, including antibiotics or local anesthetic solution? Yes/No _____

Has either parent had a lot of decay, orthodontic problems or periodontal disease? Yes/No _____

Has your child had an unfavorable experience in a medical or dental office? Yes/No _____

Do you consider your child to be high strung or generally nervous? Yes/No _____

Is your child taking any medications? Yes/No _____

When was your child weaned from bottle or breast? _____

Is your child's water fluoridated? Yes/No_____

Is your child taking a fluoride supplement? Yes/No_____

Does your child have any history of thumb or finger sucking, lip or nail biting? Pacifier use? Do they have them currently? Yes/No_____

Is there any other information about your child that will aid us in seeing him or her? _____

Parent/Guardian name _____ SS# _____/_____/_____ Date of birth _____/_____/_____

Address _____ City _____State _____Zip _____

Home number (____) _____-_____ Cell number (____) _____-_____ Email address _____

Employer _____ Dental insurance _____

Parent/Guardian name _____ SS# _____/_____/_____ Date of birth _____/_____/_____

Address _____ City _____State _____Zip _____

Home number (____) _____-_____ Cell number (____) _____-_____ Email address _____

Employer _____ Dental insurance _____

Other dental insurance _____

For billing purposes, are the parents (circle one) Married Separated Divorced Single Deceased

Nearest relative other than parents: Name & Relationship _____

Address _____ Phone (_____) _____-_____

Because your child is a minor, it is necessary that signed permission be obtained from a parent/guardian before any dental service can be started and accomplished by Dr. Knierim. Authorization is hereby granted as such. I further agree and will comply with the policy that the parent/guardian bringing the child for treatment is financially responsible. Full payment is expected on the first visit to establish an account. A charge will be added to your account for cancelled or broken appointments without a 24 hours advance notice.

Signature_____ Date _____/_____/_____