



Crystal Walker, DDS, PA

7075 W. 37th St. North, Suite B, Wichita, KS 67205

(316) 613-2077



Crystal Walker, DDS

www.jumpreachgrowsmile.com

Mariah Frazier, DDS

Office use only Child's Weight (kg) : _____
--

Today's Date: ___ / ___ / ___

Child's Name: _____ Preferred Name: _____ Male Female

Age: _____ Date of Birth: ___ / ___ / ___ School: _____ Grade: _____

Do we see any of this child's siblings (if yes, please list): _____

Address at which child resides: _____ City: _____ State: _____ Zip: _____

Person(s) authorized to bring to visits: _____

Please list any favorite interests such as favorite toys, activities, or pets that might help us to make your child feel more at home: _____

Mother's Information: (Guardian Stepmother Foster)

Single Married Other

Name: _____ DOB: ___ / ___ / ___

Phone: _____ Cell: _____

Address _____

City: _____ State: _____ Zip: _____

Father's Information: (Guardian Stepfather)

Single Married Other

Name: _____ DOB: ___ / ___ / ___

Phone: _____ Cell: _____

Address _____

City: _____ State: _____ Zip: _____

Person Responsible for Account

Name: _____ Relation to patient: _____

Billing address: _____ City: _____ State: _____ Zip: _____

Contact: _____ / _____ / _____
(home) (cell) (email)

Insurance Information

Primary Insurance:

Insured's Name: _____

Date of Birth: ___ / ___ / ___

Relationship to patient: _____

Social Security #: _____

Employer: _____

Work Phone #: _____

Dental Insurance Company: _____

Phone #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

ID #: _____

Group #: _____

Secondary Insurance:

Insured's Name: _____

Date of Birth: ___ / ___ / ___

Relationship to patient: _____

Social Security #: _____

Employer: _____

Work Phone #: _____

Dental Insurance Company: _____

Phone #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

ID #: _____

Group #: _____

How did you hear about our office? _____



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Medical History

Your child's overall health, as well as any medications which your child takes, is important to the dental care that your child receives.

Please answer the following questions completely.

Do any of the following apply to your child?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Autism | <input type="checkbox"/> Hearing or Vision Loss |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Thyroid or Endocrine Disorder | <input type="checkbox"/> ADHD | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Mental Disability | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy or Convulsions | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Hemophilia or Bleeding Dis. | <input type="checkbox"/> Mitochondrial Disorders | <input type="checkbox"/> Osteogenesis Imperfecta |
| <input type="checkbox"/> Cancer, Radiation, or Chemo | <input type="checkbox"/> Tuberculosis or Mononucleosis | <input type="checkbox"/> Neural Tube Defects | <input type="checkbox"/> Ectodermal Dysplasia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV or Aids | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Cleft Palate |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Immune Disorders | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Infective Endocarditis | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Muscular Dystrophy | _____ |

If you marked any of the conditions listed, please elaborate as to the nature of the condition: _____

Is your child taking any medications (no / yes) : _____

Is your child allergic to any medicines or food (no / yes) : _____

Has your child had to take any type of antibiotic before dental procedures in the past (no / yes) ; if yes, please explain: _____

Name of your child's Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Dental History

Last Dental Visit: _____ / _____ / _____
(Name of Dentist visited) (Approximate Date) (Phone #)

My child's attitude toward dentistry is: Favorable Unfavorable Apprehensive

What is the purpose of your child's Dental visit today? Routine Care Mouth or Tooth pain Trauma to teeth / gums

Other (Please Explain): _____

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. It is also my responsibility to inform this office of any changes in my child's medical status.

I authorize **Dr. Crystal Walker and/or Dr. Mariah Frazier** and any members of their team to perform the necessary dental services my child may need.

Parent or Guardian Signature

Today's Date