Matthew L. Keller, DMD
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We are so pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to assist you. We look forward to working with you in maintaining your child's dental health!

PATIENT INFORMATION

Child's Name: _____
LAST FIRST MIDDLE PREFFERED

☐ Male ☐ Female Date of Birth: ___/_____/_____ Social Security # _____

Hobbies: _____

Address: _____
STREET APT# CITY STATE ZIP

Home Phone#: _____ Mom's Cell#: _____ Dad's Cell#: _____

Email Address: _____

How would you prefer us to contact you regarding notice of upcoming appointments?

☐ Text ☐ Cell ☐ Home Phone

Whom may we thank for referring you to our practice? _____

PARENT'S INFORMATION

☐ Mother ☐ Stepmother ☐ Guardian Name: _____

Address: (if different from above): _____

Home # (if different from above): _____ Work # _____ ext ____ Employer: _____

Social Security # _____ DOB _____

☐ Father ☐ Stepfather ☐ Guardian Name: _____

Address: (if different from above): _____

Home # (if different from above): _____ Work # _____ ext ____ Employer: _____

Social Security # _____ DOB _____

PRIMARY INSURANCE INFORMATION

Policy Holder:_____ Relationship to patient:_____

Policy Holder's Social Security#: _____ Date of Birth:_____/_____/____

Insurance Company:_____ Employer: _____

Policy #_____ Group#_____ Telephone # of Ins Company_____

SECONDARY INSURANCE INFORMATION

Policy Holder:_____ Relationship to patient:_____

Policy Holder's Social Security#: _____ Date of Birth:_____/_____/____

Insurance Company:_____ Employer: _____

Policy #_____ Group#_____ Telephone # of Ins Company_____

DENTAL HISTORY

Last dental visit: _____/_____/_____ *Last Cleaning:*_____/_____/_____ *Last* X-rays:_____/_____/_____

Previous Dentist:_____ Do you have a copy of previous X-rays? ❑ Yes ❑ No

My child brushes his/her teeth ____times a day.

Do you ever help your child brush his/her teeth? ❑ Always ❑ Sometimes ❑ Never

Does your child floss every day? ❑ Yes ❑ No

Is there a history of bad dental experiences? ❑ Yes ❑ No

Please explain_____

Do you expect your child to be cooperative? ❑ Yes ❑ No

Is your child in pain today? ❑ Yes ❑ No

Please explain_____

Is fluoride taken in any form? ❑ Yes ❑ No

Any injuries to mouth/teeth? ❑ Yes ❑ No

Are you on well water? ❑ Yes ❑ No

Does your child do well at hair appts.? ❑ Yes ❑ No

Does your child have any mouth habits? (Please circle all that apply)

Thumb/Finger Sucking Grinding during sleep Pacifier Sleeping with bottle Other_____

Does your child have a dental condition about which you are especially concerned? _____

_____