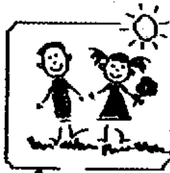

Dr. Todd J. Ayars D.D.S. P.A.

We Care About Your Kids!

Thank you for choosing us to take care of your child's dental care. We want your dental visits to be a pleasant experience. In order to receive the best care possible, please fill out this form as completely as possible. Thank you!

Child's Full Name________________ **Preferred Name**__________ **Male/Female (circle one)**

Child's Age_____ **Date Of Birth**__________ **Child's Two Favorite Things**________________

Name of Siblings______________________________

What is your reason for visiting Dr. Ayars today?________________________

What do you expect for your child's dental care?________________________

How did you hear about Dr. Ayars?____________________________

FAMILY INFORMATION

Parent(s) Child Lives With:

Father/Stepfather's Full Name:________________ **SS#**__________ **DOB**______ **DL# and State**__________

Home Address:______________________ **City:**____________ **State:**____ **Zip:**__________

Home Phone:______________ **Work Phone:**______________ **Cell Phone:**______________

Mother's/Stepmother's Full Name:________________ **SS#**__________ **DOB**______ **DL# and State**__________

Home Address:______________________ **City:**____________ **State:**____ **Zip:**__________

Home Phone:______________ **Work Phone:**______________ **Cell Phone:**______________

Person To Contact In Case of Emergency who DOES NOT live at the same address:

Name:__________________ **Phone(s)**______________ **Relationship to child**______________

DENTAL INSURANCE INFORMATION

Insured's Name:________________ **DOB:**________ **SS#:**__________ **Relationship:**__________

Insured's Address________________________ **City:**____________ **State:**____ **Zip:**________

Insured's Employer:__________________ **Work Phone:**______________ **Cell Phone:**______________

Insurance Company:________________ **Phone:**______________

Insured's Name:________________ **DOB:**________ **SS#:**__________ **Relationship:**__________

Insured's Address:______________________ **City:**____________ **State:**____ **Zip:**__________

Insured's Employer:__________________ **Work Phone:**______________ **Cell Phone:**______________

Authorization For Treatment

I authorize this dental office to perform examination, including necessary radiographs (x-rays), and after explanation, the necessary dental services deemed appropriate for the care of the above named child. In addition, I agree to pay for all charges incurred resulting from said dental treatments, including insurance deductibles and co-payments.

Signature:______________________ **Date:**______________ **Relationship:**____________

PLEASE COMPLETE THE M EDICAL AND DENTAL HISTORIES ON THE OTHER SIDE OF THIS FORM.

2611 Bolton Boone
Desoto TX 75115

972 296 9976
Email: kidstoothdoctor@yahoo.com

Dental History

Is this your child's first visit to our office? ☐ Yes ☐ No

Has your child been seen in any other dental office? ? ☐ Yes ☐ No If so, when? ____________

What was done? ____________

Date of last dental exam: ____________ Last X-rays? ____________

Has your child experienced any previous unpleasant medical or dental treatment? Please explain: ____________

Does your child have any cavities that you are aware of? ____________

Is your child having any dental pain today? ____________

Have there been any traumatic injuries to the teeth or gums? Please explain: ____________

Does your child have any dental habits such as thumbsucking or pacifier? ____________

Does your child brush every day? ____________ Do you assist with brushing and flossing? ____________

Is your child's water fluoridated? ☐ Yes ☐ No Is the child using fluoride supplements? ☐ Yes ☐ No

Is your child still breast or bottle feeding? ____________

Medical History

Name of child's physician: ____________ Phone: ____________

Address: ____________

Date of last physical exam: ____________

Is your child in good general health? ____________

Describe your child's social development ☐ Normal ☐ Advanced ☐ Delayed

Please list some words which describe your child's personality / temperament ____________

Is your child taking any medicines? ☐ Yes ☐ No

If yes, please list names and dosages ____________

____

Has your child had any reactions or allergies to any medicines? ☐ Yes ☐ No

If yes, please list ____________

____

Has your child ever had any of the following medical problems?

	Yes	No
Asthma / Lung problems	☐	☐
Food allergies / Hayfever	☐	☐
Birth defects / Cleft lip or palate	☐	☐
Difficulty with speech or hearing	☐	☐
Eye disorders	☐	☐
Kidney / Liver problems	☐	☐
Hepatitis / Jaundice	☐	☐
Epilepsy / Seizure disorder	☐	☐
Prolonged bleeding / Hemophilia	☐	☐
Blood Transfusion	☐	☐
Diabetes	☐	☐
Heart disease / Heart murmur	☐	☐
Rheumatic fever	☐	☐
Disorder of the endocrine system	☐	☐

	Yes	No
Tuberculosis (TB)	☐	☐
Leukemia	☐	☐
Tumors or malignancies	☐	☐
HIV positive / AIDS	☐	☐
Recurrent infections	☐	☐
Any stays in the hospital	☐	☐
Any operations	☐	☐
Trauma / Injury	☐	☐
Recurrent Headaches	☐	☐
Problems with jaw joint (TMJ / TMD)	☐	☐
Behavior or learning difficulties	☐	☐
Mental Retardation	☐	☐
Handicaps / Disabilities	☐	☐

Other ____________

____

Medical History Updates

(Please mark any changes to your child's medical history above.)

Parent's signature: ____________ Date: ________ Parent's signature: ____________ Date: ________

Parent's signature: ____________ Date: ________ Parent's signature: ____________ Date: ________

Parent's signature: ____________ Date: ________ Parent's signature: ____________ Date: ________

Parent's signature: ____________ Date: ________ Parent's signature: ____________ Date: ________

Parent's signature: ____________ Date: ________ Parent's signature: ____________ Date: ________

Parent's signature: ____________ Date: ________ Parent's signature: ____________ Date: ________

Comments: ____________

____