Bloomington Pediatric Dentistry
Dr. Kyle Taylor, D.D.S.
Dr. Tamara Gierke, D.D.S.

Welcome to our practice!
We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child good oral habits, which will keep their smile beautiful for their lifetime.

Child's Name
_____
Last First MI

Child's Nickname_____

Child's Birth date_____ Age_____ Sex_____

Home Address_____

City_____ Zip_____

Home Phone # _____

Cell Phone # _____

Alternate Contact_____ Phone_____

Names of other children in family_____

Referred by _____

Responsible Party Information

Name_____

Relationship_____

Home Address_____

City_____ Zip_____

Home Phone# _____ Cell_____

SSN#_____ DOB_____

Employer_____

Work Phone #_____

Email Address_____

Parent's Marital Status: Married Divorced Separated Widowed Single Remarried

Primary Dental Insurance

CO Name_____

Address_____

Phone#_____ Insured ID#_____

Group#_____ Insured's Name_____

Relation_____ DOB_____

Insured Employer_____

SSN# _____

Secondary Dental Insurance

CO Name_____

Address_____

Phone#_____ Insured ID#_____

Group#_____ Insured's Name_____

Relation_____ DOB_____

Insured Employer_____

SSN# _____

Child's Physician

_____

City/State_____ Phone#_____

Date of last exam_____ Results _____

Health History

Has your child ever had any of the following:

AIDS/HIV _____
Anemia _____
Asthma _____
Autism _____
Bladder Problems _____
Cancer _____
Cerebral Palsy _____
Congenital Birth Defects _____
Convulsions/Fainting _____
Diabetes _____
Epilepsy _____
Eating Disorder _____
Speech/Hearing Problems _____
Heart Problems/Murmur _____
Hepatitis _____
Mouth Breather _____
Pregnant _____
Prolonged Bleeding/Bruises easily _____
Psychological/Emotional Problems _____
Rheumatic Fever _____
Sinus Problems _____
Tuberculosis _____
Allergies _____

_____

Do you consider your child to be

Advanced in the learning process _____
Progressing normally _____
Slow in the learning process _____

Please explain any medical problems your child has/ had or any medications currently taking_____

_____
_____
_____

Date of the last dental visit_____

Previous Dentist_____

Has your child had any difficulty with previous dental visits?_____

_____

Have there been any injuries to teeth, face, or mouth?

_____

_____

Why did you bring your child to the dentist today?____

_____

_____

Is your child breastfed? Yes/No Until what age_____

Does your child still take a bottle or a sippy cup? Yes/No

What is your child's favorite fluid to drink? Water, Kool-aid, Apple juice, Other Juice, Milk, Formula, Tea, Soft drink, Sports drinks, or other

How often does your child brush?_____

Do you help w/ brushing?_____

How often does your child floss?_____

Is child's water fluoridated?_____

Does your child:

Suck thumb or finger _____
Bite/suck lips _____
Bite/chew nails _____
Grind teeth _____
Clench jaws _____
Chew hard objects _____
Use a pacifier _____

Parent/Guardian Signature and date

_____