Kierland Dental Center
Michael R. Thompson, DDS, PC
7102 E. Acoma Dr., Ste #3 * Scottsdale, AZ 85254 * (480) 556-0310

YOUR CHILDS INFORMATION **Male____Female_____**

Name:_____Nickname:_____Date of Birth_____

Child's Home Phone: _____Parent's Email for Reminders:_____

Address:_____City:_____State_____Zip_____

School name:_____Age:_____Grade:_____Interests:_____

Emergency Contact Name:_____Phone#_____Relationship:_____

MEDICAL INFORMATION

1. **Please circle which of the following you have had, or have at present:**

Anemia	Cough up Blood	High Blood Pressure	Shortness of Breath
Arthritis, Rheumatism	Cough, Persistent	HIV/AIDS	Skin Rash
Artificial Heart Valves	Diabetes	Jaw Pain	Snoring/Sleep Apnea
Artificial Joints, Pins, etc	Epilepsy	Kidney Disease	Stroke
Asthma	Fainting	Liver Disease	Surgical Implant
Back Problems	Glaucoma	Mitral Valve Prolapse	Swelling of Feet or Ankles
Bleeding Abnormally	Headaches	Multiple Myeloma	Thyroid Problems
Cancer	Heart Murmur	Osteoporosis	Tobacco Habit
Chemical Dependency	Heart Problems	Pacemaker	Tonsillitis
Chemotherapy	Hemophilia	Radiation Treatment	Tuberculosis
Circulatory Problems	Hepatitis Type: A B C	Respiratory Disease	Ulcer
Congenital Heart Lesions	Hernia Repair	Scarlet Fever	Venereal Disease
Cortisone Treatments			

ANY DISEASE, CONDITION OR PROBLEM NOT LISTED: _____

NONE OF THE ABOVE.

2. ***List medications you are currently taking and the correlating diagnosis:***

_____

_____

3. **Ear, Nose and Throat ~ Please check which of the following you have had, or have at present:**

☐ A sore throat that does not heal	☐ A white or red patch in your mouth	☐ Pain on chewing or opening your mouth
☐ Difficulty in swallowing	☐ Persistent hoarseness	☐ Persistent pain in the ear
☐ Loss of smell, a bloody nasal discharge, or coughing up blood	☐ A lump or mass in the neck that does not heal	☐ Persistent bad breath
		☐ Persistent nasal congestion

Responsible Party

Name of Person

Responsible for this Account:_____ **Relation to Patient:**_____

Address: _____ **Phone:** _____

Driver's License #: _____ **Birthday:**_____

Employer: _____ **Work Phone:** _____

Is he/she currently a patient in our office? ___ Yes __ No E-Mail: _____

Primary Insurance Information

Name of Insured: _____ **Relation to Patient:** _____

Birthday:_____ **Social Security #:** _____**Date Employed:** _____

Employer: _____ **Work Phone:** _____

Employer Address: _____**City:** _____**State:** _____**Zip:**

Insurance Company: _____**Group #**_____

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

Insurance ID#: _____ **Insurance Phone:** _____

Secondary Insurance

Name of Insured: _____**Relation to Patient:** _____

Birthday:_____ **Social Security #:** _____**Date Employed:** _____

Employer: _____ **Work Phone:** _____

Employer Address: _____**City:** _____**State:** _____**Zip:** _____

Insurance Company: _____**Group #**_____

Address: _____**City:** _____ **State:** ____ **Zip:** _

Insurance ID#: _____ **Insurance Phone:** _____