



Hewitt Kids Dental

113 Burnett Ct.
Woodway, TX 76712
P: 254-224-6008
F: 254-224-6022

INFORMATION SHEET

Today's Date _____

Patient's Name: _____
FIRST MI LAST

Date of Birth: _____ Age: _____ Sex: Male or Female (Please circle)

Phone 1: (____) _____ Phone 2: (____) _____

Address: _____ City: _____ Zip: _____

Email: _____ Do you prefer **text** or **e-mail**?

Patient's Medicaid: MCNA/CHIP, DENTAQUEST/CHIP, TRADITIONAL ID # _____

What is your child's school or day-care? _____

Other siblings that are seen in our office: _____

Who is accompanying the child today? (Name & Relation): _____

Child resides with: (circle one) Both Parents, Mother, Father, Other: _____

Father or Guardian's Information: (please circle) **Father, Stepfather, Guardian**

Name: _____ Date of Birth: _____

Phone# (____) _____ SSN _____ DL# _____

Email: _____ Employer: _____

Insurance Information

Insurance Name: _____ Insurance Phone# _____

Group # _____ ID # _____

Mother or Guardian's Information: (please circle) **Mother, Stepmother, Guardian**

Name: _____ Date of Birth: _____

Phone# (____) _____ SSN _____ DL# _____

Email: _____ Employer: _____

Insurance Information

Insurance Name: _____ Insurance Phone# _____

Group # _____ ID # _____

Emergency Contact:

Name: _____ Relation: _____ Phone : (____) _____

Whom may we thank for referring you? _____

Previous/Present Dentist: _____ Last Visit: _____

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

Is your child currently in pain? **YES or NO**



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Does your child require antibiotics before dental treatment? **YES or NO**

Has your child ever had a serious/difficult problem with any dental work? **YES or NO**

Child's Medical Doctor: _____ Phone# _____

List any prescribed or over the counter medications or vitamins that your child is taking:

List all of your child's allergies (food, medication, latex, metals/nickel, red dye, etc.):

Has your child experienced any of the following medical problems?

ADD/ADHD	Y or N
Autism Spectrum Disorder	Y or N
Any Hospital Stays/Operations	Y or N
Artificial Bones/Joints/Valves	Y or N
Asthma	Y or N
Cancer	Y or N
Congenital Heart Defect	Y or N
Convulsions, Epilepsy	Y or N
Diabetes, Immune Disorders	Y or N
Intellectual or Developmental Delay	Y or N
Hearing Impairment	Y or N
Heart Murmur	Y or N
High Blood Pressure	Y or N
Hives, Eczema or other Skin Conditions	Y or N
Kidney Problems	Y or N
Liver Problems	Y or N
Sickle Cell Disease, Bleeding Disorders	Y or N
Rheumatic Fever	Y or N
Tuberculosis	Y or N

Any other medical diagnoses or conditions? _____

Does your child experience any of the following?

Chewing on objects	Y or N	Speech Delay	Y or N
Grinding teeth	Y or N	Mouth Breathing	Y or N
Lip sucking/biting	Y or N	Thumb/Finger Sucking	Y or N
Nail Biting	Y or N	Pacifier	Y or N
Goes to bed with a bottle	Y or N		

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control by OSHA, the CDC and the ADA. I affirm that the information I have provided is to the best of my knowledge. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent/Guardian _____ Date: _____



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The Health Insurance Portability and Accountability Act (HIPAA)

Patient Name _____

Date of Birth _____

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. The Administrative Simplification portion of HIPAA required the U.S. Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data.

Hewitt Kids Dental Notice of Privacy Practices describes Hewitt Kids Dental policies in regard to HIPAA. This notice describes how medical information about you or your child may be used and disclosed and how you can get access to this information. Please review it carefully and sign below.

Yes, I've read Hewitt Kids Dental's Notice of Privacy Practices.

Signature of Patient or Parent/Guardian _____

Relationship to the child _____

Print Name _____

Date _____