



WELCOME

Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First Middle

Child's Birthdate: ___/___/___ Child's Age: _____

Nickname: _____ Male Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: () _____

Social Security #: _____

Child's Home Address: _____
#Apt. / Condo

City _____ State _____ Zip Code _____

General Information

Who is accompanying the child today? _____

Name: _____ Relation: _____

Do you have legal custody of the child? Yes No

Who may we thank for referring you? _____

Other siblings: _____

Previous/ Present Dentist: _____ Last visit date: _____

Dentist Phone #: () _____

Relative or friend not living with you: _____

Name: _____ Phone #: () _____

Address: _____
City State Zip Code

Parent's Information

Person responsible for Account: _____ Parent's Marital Status: Married Single Partnered Divorced Separated

Father Step Father Guardian

Name: _____ Birthdate: ___/___/___

Address: (if different than Child's): Hm#: () _____

SS #: _____ DL#: _____

Wk #: () _____ Ext: _____ Cell/other #: () _____

E-mail: _____

Employer: _____

Employer's Address: _____
City State Zip Code

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____
City State Zip Code

Insurance Phone #: () _____

Group # (Plan, Local or Policy #): _____

Mother Step Mother Guardian

Name: _____ Birthdate: ___/___/___

Address: (if different than Child's): Hm#: () _____

SS #: _____ DL#: _____

Wk #: () _____ Ext: _____ Cell/other #: () _____

E-mail: _____

Employer: _____

Employer's Address: _____
City State Zip Code

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____
City State Zip Code

Insurance Phone #: () _____

Group # (Plan, Local or Policy #): _____

Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian

Date

Dental History

Medical History

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

Has the child ever taken any diet pills such as Phen-Fen? Yes No
 (Also known as Redux or Pondimin) If so, when? _____

Is the child currently in pain? Yes No

Does the child require antibiotics before dental treatment? Yes No

Has the child ever had a serious/difficult problem associated with previous dental work? Yes No

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? Yes No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Does the child floss his/her teeth daily? Yes No

Child's Physician: _____

Phone #: () _____ Date of Last Visit: _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health:

Good Fair Poor

Please list any drugs that the child is currently taking: _____

Please list all drugs that the child is allergic to: _____

Y N Allergic to Latex Y N Allergic to Metals

Y N Allergic to Nickel Y N Allergic to Plastic

Has the child experienced any of the following medical problems?

- | | |
|--------------------------------------|---------------------------|
| Y N Abnormal Bleeding/
Hemophilia | Y N Heart Murmur |
| Y N ADD/ADHD | Y N Hepatitis |
| Y N AIDS/HIV + | Y N High Blood Pressure |
| Y N Anemia | Y N Hives |
| Y N Any Hospital Stays/Operations? | Y N Kidney Problems |
| Y N Artificial Bones/Joints/Valves | Y N Liver Problems |
| Y N Asthma | Y N Low Blood Pressure |
| Y N Cancer | Y N Lupus |
| Y N Chicken Pox | Y N Measles |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Convulsions | Y N Mononucleosis |
| Y N Diabetes | Y N Prosthetics |
| Y N Epilepsy | Y N Rheumatic Fever |
| Y N Exposed to HIV, but Neg. | Y N Scarlet Fever |
| Y N Handicaps/Disabilities | Y N Skin Rash |
| Y N Hearing impairment | Y N Tuberculosis (TB) |

Are the child's immunizations current? Yes No

Is there anything you would like to discuss with the Doctor in Private? Yes No

Please discuss any serious medical problems the child experiences/ed:

Does/did the child experience any of the following?

- | | |
|------------------------------|---------------------------|
| Y N Breast Fed | Y N Nursing Bottle Habits |
| Y N Chewing on Objects | Y N Speech Problems |
| Y N Clenching/Grinding Teeth | Y N Thumb/finger Sucking |
| Y N Lip Sucking/Biting | Y N Tongue/Cheek Sucking |
| Y N Mouth Breather | Y N Tongue Thrust |
| Y N Nail Biting | Y N Used Pacifier |

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control made by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

 Signature of Parent or Guardian

 Date

OFFICE USE ONLY

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I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

 Signature of Dentist

 Date

Dentist's Comments: _____

Medical History Update

Has there been any change in your child's health status since their last visit? Yes No

If Yes, Please explain: _____

Has there been any change in your child's health status since their last visit? Yes No

If Yes, Please explain: _____

 Parent /Guardian Signature

 Date

 Dentist Signature

 Date

 Parent /Guardian Signature

 Date

 Dentist Signature

 Date