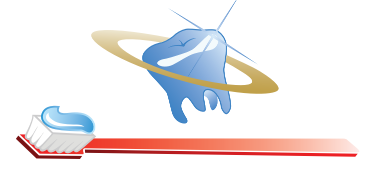
WELCOME



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

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 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 Nickel
Y N Allergic to Metals
Y N Allergic to Plastic

Medical History

Has the child experienced any of the following medical problems?

Y N Abnormal Bleeding/ Hemophilia
Y N ADD/ADHD
Y N AIDS/HIV+
Y N Anemia
Y N Any Hospital Stays/Operations?
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Exposed to HIV, but Neg.
Y N Handicaps/Disabilities
Y N Hearing impairment
Y N Heart Murmur
Y N Hepatitis
Y N High Blood Pressure
Y N Hives
Y N Kidney Problems
Y N Liver Problems
Y N Low Blood Pressure
Y N Lupus
Y N Measles
Y N Mitral Valve Prolapse
Y N Mononucleosis
Y N Prosthetics
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Skin Rash
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 Chewing on Objects
Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/finger Sucking
Y N Tongue/Cheek Sucking
Y N Tongue Thrust
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 OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

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