Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____
LAST FIRST MI

Nickname: _____ ☐ Male ☐ Female

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

School: _____ Grade: _____

Child's Home #: _____ SS #: _____

Child's Home Address

_____
APT/CONDO #

_____
CITY STATE ZIP

2 Who is Accompanying the Child Today

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Who may we Thank for referring you? _____

Other family members seen by us: _____

_____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

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

3 Mother's Information: (☐ Step Mother ☐ Guardian)

Name: _____

WK #: _____ Ext: _____ HM #: _____

Employer: _____

SS #: _____ DL #: _____

Father's Information: (☐ Step Father ☐ Guardian)

Name: _____

WK #: _____ Ext: _____ HM #: _____

Employer: _____

SS #: _____ DL #: _____

4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

WK #: _____ Ext _____ HM #: _____

Employer: _____

DL #: _____ SS #: _____

Who is responsible for making appointments?

Name: _____

WK #: _____ Ext _____ HM #: _____

5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

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

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: ___/___/___ & SS#: _____

Insured's Employer: _____

Orthodontic Coverage? ☐ Yes ☐ No

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

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

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: ___/___/___ & SS#: _____

Insured's Employer: _____

Orthodontic Coverage? ☐ Yes ☐ No

CONTINUED ON BACK OF FORM

6 **Why did you bring the child to the dentist today?** _____

_____

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 their jaw joint (TMJ / TMD)? ☐ **Yes** ☐ **No**

Does the child brush their teeth daily? ☐ Yes ☐ No

Floss their 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 all drugs that the child is currently taking: _____

_____

_____

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

_____

_____

7 **Has the child ever had any of the following medical problems?**

Y	N	Heart Murmur	Y	N	Congenital Heart Defect
Y	N	Cancer	Y	N	Convulsions / Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheumatic Fever	Y	N	Hearing Impairment
Y	N	HIV+ / AIDS	Y	N	Any Operations
Y	N	Hemophilia	Y	N	Any stays in a hospital
Y	N	Asthma	Y	N	Kidney / Liver Problems
Y	N	Hepatitis	Y	N	Handicaps / Disabilities
Y	N	Tuberculosis(TB)	Y	N	Allergies to any drugs

Please discuss any serious medical problems that the child has had: _____

_____

_____

8 **Does the child have any of the following habits?**

Y	N	Thumb / Finger Sucking
Y	N	Lip Sucking/ Biting
Y	N	Nail Biting
Y	N	Nursing Bottle Habits

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

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

_____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

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

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

Medical History Update

1. Date: _____ Signature: _____

Comments: _____

_____

2. Date: _____ Signature: _____

Comments: _____

_____

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