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: _____

Nickname:_____ ☐male ☐female

Child's birth date:_____ Child's age: _____

School:_____ Grade: _____

Child's home#:_____ SS#: _____

E-mail address:_____

Child's Home Address:

_____

_____

2 Who Is Accompanying The Child Today?

Name:_____ Relation:_____

Do you have legal custody of this child? ☐Y ☐N

Whom may we thank for referring you?_____

Other family members seen by us: _____

Previous / Present Dentist:_____

Last visit date:_____

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

3 Mother's Information

Name:_____ Birth date:_____

Work#:_____ Ext:____ Home#: _____

Employer:_____

SS#:_____ **DL#:**_____

Father's Information

Name:_____ Birth date:_____

Work#:_____ Ext:____ Home#: _____

Employer:_____

SS#:_____ **DL#:**_____

4 Person Responsible For Account

Name:_____ Relation:_____

Billing address:_____

Home#:_____ DL#:_____

Employer:_____

Work#:_____ SS#:_____

Who is responsible for making appointments?

Name:_____

Work#:_____ Home#:_____

5 Primary Dental Insurance

Insurance co. name:_____

Insurance co. address:_____

Insurance co. phone#:_____

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

Policy Owner's name:_____

Relationship to Patient:_____

Policy Owner's Birth date:_____ SS#:_____

Policy Owner's Employer:_____

Employer's Address:_____

Orthodontic Coverage? ☐Y ☐N

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address:_____

Insurance Co. Phone#: (___) _____

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

Policy Owner's name:_____

Relationship to Patient:_____

Policy Owner's Birth date:__/__/__ SS#_____

Policy Owner's Employer:_____

Employer's Address: _____

Orthodontic Coverage? ☐Yes ☐No

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 his/ her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

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

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

Has your child ever taken Phen-Fen? ☐ Yes ☐ No

(also known as Redux or Pondimin) if so, when?_____

Please list all drugs that the child is currently taking:

_____

_____

Please list all drugs /materials that the child is allergic to:

_____

_____

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

Y N Abnormal Bleeding
Y N ADD / ADHD
Y N Allergies to any drugs
Y N Any Hospital Stays
Y N Any operations
Y N Artificial Bones/joints/ valves
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions/ Epilepsy
Y N Diabetes
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV+ / AIDS
Y N Kidney / Liver Problems
Y N Rheumatic/ Scarlet Fever
Y N Sickle Cell Disease / Traits
Y N Tuberculosis (TB)

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

_____

8 Does/did the child have any of the following habits?

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

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

Neighbor or Relative not living with you.

Name:_____ Phone:(___)_____

Address_____

_____

_____

9

I understand that the information that I have given is correct to the best of my knowledge, that is will be held in the strictest of confidence and it is my responsibility to inform this office of nay 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_____

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

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:_____

_____