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 preventative 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#: _____

E-mail Address: _____

Child's Home Address: _____

_____
City State Zip

2 Who Is Accompanying The Child Today?

Name: _____ Relation: _____

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

Whom may we thank for referring you? _____

Other family members seen by us: _____

_____

Previous/Present Dentist: _____

Last Visit Date: _____

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

3 Mother's Information

❑ Stepmother ❑ Guardian

Name: _____ Birthdate: ____/____/____

Wk #: (____)_____ Ext. ___ Home #: (____)_____

Employer: _____

SS#: _____ DL#: _____

Father's Information

❑ Stepfather ❑ Guardian

Name: _____ Birthdate: ____/____/____

Wk #: (____)_____ Ext. ___ Home #: (____)_____

Employer: _____

SS#: _____ DL#: _____

4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____
City State Zip

Home #: (____)_____ DL#: _____

Employer: _____

Wk #: (____)_____ Ext. ___ SS#: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____)_____ Ext. ___ Home #: (____)_____

5 Primary Dental Insurance

Insurance Co. Name: _____

Ins. Co. Address: _____

_____

Ins. Co. Phone #: (____)_____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ SS#: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ❑ Yes ❑ No

Secondary Dental Insurance

Insurance Co. Name: _____

Ins. Co. Address: _____

_____

Ins. Co. Phone #: (____)_____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ SS#: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ❑ Yes ❑ No

6 Medical History

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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 If yes, please explain: _____

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 If yes, please explain: _____

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

Is the child allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics

❑ Other, please explain: _____

Does the child have, or had, any of the following?

- ❑ Abnormal Bleeding
- ❑ ADD/ADHD
- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problems
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Handicaps/Disabilities
- ❑ Hay Fever
- ❑ Hearing Impairment
- ❑ Heart Attack/Failure
- ❑ Heart Murmur
- ❑ Heart Pace Maker
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsilitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, please explain: _____

Comments: _____

_____

_____

_____

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

- ❑ Lip Sucking/Biting
- ❑ Nail Biting
- ❑ Nursing Bottle Habits
- ❑ Thumb/Finger Sucking

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____