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 Hm #: (____)_____ SS #: _____

Child's Home Address:

_____
APT /CONDO #

_____
CITY STATE ZIP

Email Address: _____

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: _____
(Please Circle)

Last Visit Date: _____

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

3 Parent: ☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

Cell #:(____)_____ Hm #:(____)_____

Employer: _____ Wk #:(____)_____

SS #: _____ DL #: _____

Parent: ☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

Cell #:(____)_____ Hm #:(____)_____

Employer: _____ Wk #:(____)_____

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 #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

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

Policy Owner's Employer: _____

Orthodontic Coverage? ☐ Yes ☐ No

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 Birthdate: ____/____/____ ID #: _____

Policy Owner's Employer: _____

Orthodontic Coverage? ☐ Yes ☐ No

CONTINUED ON BACK

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 been prescribed Fosamax or any other bisphosphonate? ☐ Yes ☐ No
If so, when? _____

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking:

_____

_____

Aside from items below, list all drugs/materials that the child is allergic to:

_____

_____

Latex? ☐ Yes ☐ No Metals/Nickel? ☐ Yes ☐ No Plastic? ☐ Yes ☐ No

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

Y N	Abnormal Bleeding	Y N	Diabetes
Y N	ADD / ADHD	Y N	Handicaps / Disabilities
Y N	Any Hospital Stays	Y N	Hearing Impairment
Y N	Any Operations	Y N	Heart Murmur
Y N	Artificial Bones / Joints	Y N	Hemophilia
Y N	Asperger Syndrome	Y N	Hepatitis
Y N	Asthma	Y N	HIV+ / AIDS
Y N	Autism	Y N	Kidney / Liver Problems
Y N	Cancer	Y N	Rheumatic / Scarlet Fever
Y N	Congenital Heart Defect	Y N	Sickle Cell Disease / Traits
Y N	Convulsions / Epilepsy	Y N	Tuberculosis (TB)

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

_____

8 Does/did the child experience any of the following?

Y N	Lip Sucking / Biting	Y N	Mouth Breather
Y N	Speech Problems	Y N	Tongue Thrust
Y N	Nail Biting	Y N	Nursing Bottle Habits
Y N	Thumb / Finger Sucking	Y N	Clenching / Grinding Teeth

Our office is HIPAA Compliant and 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 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: _____

_____