

Welcome



Tell Us about Your Child

Today's Date: _____

Child's Name: _____
Last First MI

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

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (____) _____ SS #: _____

Child's Home Address: _____
Apt / Condo # _____

City State Zip



General Information

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 siblings: _____

Previous / Present Dentist: _____ Last Visit Date _____

Dentist's Phone #: (____) _____

Relative or Friend not living with you:
Name: _____ Phone: (____) _____

Address: _____
City State Zip



Parent's Information

Person Responsible for Account: _____ Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ **Father** ☐ Step Father ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (____) _____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____
City State Zip

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 #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____
City State Zip

Insurance Phone: (____) _____

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



Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits other wise 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

Continued on Back



Dental History



Medical History

Why did you bring the child to 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 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

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

Aside from items listed, please list all drugs/things that the child is allergic to: _____

Yes No Latex Yes No Metals/Nickel Yes No Plastic

Has the child experienced the following medical problems?

<input type="checkbox"/> Y <input type="checkbox"/> N	Abnormal Bleeding / Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Murmur
<input type="checkbox"/> Y <input type="checkbox"/> N	ADD/ADHD	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis
<input type="checkbox"/> Y <input type="checkbox"/> N	AIDS/HIV+	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N	Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Hives
<input type="checkbox"/> Y <input type="checkbox"/> N	Any Hospital Stays/Operations?	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Problems
<input type="checkbox"/> Y <input type="checkbox"/> N	Artificial Bones/Joints/Valves	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Problems
<input type="checkbox"/> Y <input type="checkbox"/> N	Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Low Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Lupus
<input type="checkbox"/> Y <input type="checkbox"/> N	Chicken Pox	<input type="checkbox"/> Y <input type="checkbox"/> N	Measles
<input type="checkbox"/> Y <input type="checkbox"/> N	Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N	Mitral Valve Prolapse
<input type="checkbox"/> Y <input type="checkbox"/> N	Convulsions	<input type="checkbox"/> Y <input type="checkbox"/> N	Mononucleosis
<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Prosthetics
<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever
<input type="checkbox"/> Y <input type="checkbox"/> N	Exposed to HIV, but Neg.	<input type="checkbox"/> Y <input type="checkbox"/> N	Scarlet Fever
<input type="checkbox"/> Y <input type="checkbox"/> N	Handicaps/Disabilities	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin Rash
<input type="checkbox"/> Y <input type="checkbox"/> N	Hearing Impairment	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

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?

<input type="checkbox"/> Y <input type="checkbox"/> N	Breast Fed	<input type="checkbox"/> Y <input type="checkbox"/> N	Nursing Bottle Habits
<input type="checkbox"/> Y <input type="checkbox"/> N	Chewing on Objects	<input type="checkbox"/> Y <input type="checkbox"/> N	Speech Problems
<input type="checkbox"/> Y <input type="checkbox"/> N	Clenching/Grinding Teeth	<input type="checkbox"/> Y <input type="checkbox"/> N	Thumb/Finger Sucking
<input type="checkbox"/> Y <input type="checkbox"/> N	Lip Sucking/Biting	<input type="checkbox"/> Y <input type="checkbox"/> N	Tongue/Cheek Biting
<input type="checkbox"/> Y <input type="checkbox"/> N	Mouth Breather	<input type="checkbox"/> Y <input type="checkbox"/> N	Tongue Thrust
<input type="checkbox"/> Y <input type="checkbox"/> N	Nail Biting	<input type="checkbox"/> Y <input type="checkbox"/> N	Used Pacifier

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.

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

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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? ☐ Y ☐ N

If Yes, please explain. _____

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. _____

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____