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.

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: _____

Child's Home Phone: (___) _____ SS #: _____

Child's Home Address: _____
Apt/Condo #

_____
City State Zip

Parent's Information

Mother

❑ Stepmother ❑ Guardian

Name: _____ Birthdate: _____

Work Phone: (___) _____ Home Phone: (___) _____

Employer: _____

Length of Employment: _____ Social Security #: _____

Father

❑ Stepfather ❑ Guardian

Name: _____ Birthdate: _____

Work Phone: (___) _____ Home Phone: (___) _____

Employer: _____

Length of Employment: _____ Social Security #: _____

Who Is Accompanying The Child Today?

Name: _____ Relation: _____

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

Is the child adopted? ❑ Yes ❑ No

Is the child in a foster home? ❑ Yes ❑ No

Whom may we thank for referring him/her? _____

Other siblings seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

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

Emergency contact: not living with child:

Name: _____

Address: _____

Home # _____ **Work** _____

Person Responsible for Account

Name: _____

Billing Address: _____

_____
City State Zip

Employer: _____ Driver's License #: _____

Work Phone: (___) _____ Home Phone: (___) _____

Relationship: _____ Social Security #: _____

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.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. My method of payment will be _____

_____
Signature Date

Primary Insurance

Dental Coverage ❑ Yes ❑ No Orthdontic Coverage ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone: (___) _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

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

Policy Owner's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Insurance

Dental Coverage ❑ Yes ❑ No Orthdontic Coverage ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone: (___) _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

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

Policy Owner's Employer: _____

Employer's Address: _____

_____
City State Zip

Child's Name:_____ Birthdate:___ /___ /____

Parent's Name: _____

Today's Date: _____ Home Phone: (_____) _____

Welcome

What is the primary reason for today's visit?

_____

_____

Your child's current dental health: ❑ Good ❑ Fair ❑ Poor

Has the child experienced problems associated with previous dental work? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No

Do you like his/her smile? ❑ Yes ❑ No

If not, why?_____

Does he/she have bleeding gums? ❑ Yes ❑ No

Does your child floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on toothbrush? ❑ Hard ❑ Medium ❑ Soft

How long does he/she use a toothbrush before replacing it? _____

Are his/her teeth sensitive to heat, cold, or anything else?_____

Has he/she lost any teeth? ❑ Yes ❑ No If yes, why?_____

_____

Have there been any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No

List any musical instruments played:

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has your child been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Has puberty begun? (Boys) ❑ Yes ❑ No

Has his voice changed? ❑ Yes ❑ No

Date menstruation began? (Girls) _____

Is she taking birth control pills? ❑ Yes ❑ No

Is she pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Is she nursing? ❑ Yes ❑ No

OFFICE USE ONLY OFFICE USE ONLY

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

Iniitals:_____ Date: _____

Doctor's Comments: _____

_____

_____

Medical History Update

1. Date:_____ Signature:_____

Comments: _____

_____

2. Date:_____ Signature:_____

Comments: _____

_____

Child's Physician: _____

Phone #: (_____)_____ Date of Lost Visit: _____

Is the child currently under the care of a physician? ❑ Yes ❑ No

Please describe your child's current physical health ❑ Good ❑ Fair ❑ Poor

Please list all drugs that your child is currently taking: _____

_____

Please list all drugs that cause your child allergic reactions: _____

_____

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	AIDS	Y	N	Hepatitis
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Any Hospital Stays	Y	N	Hives
Y	N	Any Operations	Y	N	HIV+
Y	N	Asthma	Y	N	Immunizations Current
Y	N	Cancer	Y	N	Kidney
Y	N	Chicken Pox	Y	N	Liver Problems
Y	N	Congenital Hearth Defect	Y	N	Low Blood Pressure
Y	N	Convulsions	Y	N	Measles
Y	N	Diabetes	Y	N	Mononucleosis
Y	N	Epilepsy	Y	N	Rheumatic Fever
Y	N	Exposed to HIV, but Neg.	Y	N	Scarlet Fever
Y	N	Handicaps / Disabilities	Y	N	Skin Rash
Y	N	Hearing Impairment	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur			

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
Y	N	Chewing on Objects	Y	N	Tongue / Cheek Biting
Y	N	Mouth Breather	Y	N	Speech Problems
Y	N	Clenching / Grinding Teeth	Y	N	Tongue Thrust
Y	N	Used Pacifier?	Y	N	Breast Fed?

Please discuss any serious medical problems the child experiences/ed: _____

_____

_____

Anything you would like to discuss with the Doctor in private? ❑ Yes ❑ No

_____

_____

I affirm that the information I have given is correct to the best of my knowledge. I understand 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