

# 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 Home #: (\_\_\_\_) \_\_\_\_\_ SS #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

#### Child's Home Address:

\_\_\_\_\_  
CITY STATE ZIP APT/CONDO #

## 4

### Person Responsible For Account

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY STATE ZIP

Hm #: (\_\_\_\_) \_\_\_\_\_ DL #: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ SS #: \_\_\_\_\_

#### Who is responsible for making appointments?

Name: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

## 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  Partnered  
 Married  Divorced  Separated

## 3

#### Mother's Information: Step Mother Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Email Address: \_\_\_\_\_

Hm #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Wk #: (\_\_\_\_) \_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

#### Father's Information: Step Father Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Email Address: \_\_\_\_\_

Hm #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Wk #: (\_\_\_\_) \_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

## 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:** \_\_\_\_\_

Employer's Address: \_\_\_\_\_

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:** \_\_\_\_\_

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 Fosamax, or any other bisphosphonate?  Yes  No

Has your child ever taken Phen-Fen?  Yes  No

Please list all drugs that the child is currently taking: \_\_\_\_\_

\_\_\_\_\_

Please 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?**

- |  |  |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding                  | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHD                           | <input type="checkbox"/> Y <input type="checkbox"/> N Handicaps / Disabilities     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies to any drugs             | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays                 | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Operations                     | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                             | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                             | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney / Liver Problems      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect            | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions / Epilepsy             | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
|  | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)            |

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

\_\_\_\_\_

\_\_\_\_\_

# 8

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

- |  |  |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Lip Sucking / Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Nursing Bottle Habits  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting          | <input type="checkbox"/> Y <input type="checkbox"/> N Thumb / Finger Sucking |

**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.**

Neighbor or Relative not living with you.

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

# 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 \_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_