WELCOME!

We would like to welcome 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: __________

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

Who is responsible for account? ______________ Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

Parent: ☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: ______________________________ Birthdate: ___/___/___

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

____

____

SS #: ____________________ DL #: ____________________

Wk #: (_____)____________ Ext: ________ Cell #: (_____) __________

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 #): ____________________

Parent: ☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: ______________________________ Birthdate: ___/___/___

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

____

____

SS #: ____________________ DL #: ____________________

Wk #: (_____)____________ Ext: ________ Cell #: (_____) __________

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 otherwise 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

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Dental & Medical History

Why did you bring the child to the dentist today? ______________________

____

____

Has the child ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No
Has your child ever taken Phen-Fen? ☐ Yes ☐ No
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 supplement drugs that the child is currently taking:

____

____

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

____

Y N Latex Y N Metals/Nickel Y N Plastic

Has the child experienced the following medical problems?

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

Y	N	Breast Fed	Y	N	Nursing Bottle Habits
Y	N	Chewing on Objects	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Thumb/Finger Sucking
Y	N	Lip Sucking/Biting	Y	N	Tongue/Cheek Biting
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	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. ______________________________

____

____
Parent/Guardian Signature Date

____
Dentist Signature Date

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

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