

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

**Child's Home Address:**

\_\_\_\_\_

APT/CONDO #

\_\_\_\_\_

CITY                      STATE                      ZIP

**4 Person Responsible for Account**

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

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

\_\_\_\_\_

WK #: \_\_\_\_\_ Ext: \_\_\_\_\_

HM #: \_\_\_\_\_

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

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

**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

Who 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                       Widowed  
 Married                       Divorced                       Separated

**3 Mother's Information:**    ( Step Mother  Guardian)

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

WK #: \_\_\_\_\_ Ext: \_\_\_\_\_ HM# \_\_\_\_\_

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

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

**Father's Information:**    ( Step Father  Guardian)

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

WK #: \_\_\_\_\_ Ext: \_\_\_\_\_ HM# \_\_\_\_\_

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

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

**5 Primary Dental Insurance**

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone#: \_\_\_\_\_

Group # (plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insured's Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Insured's Employer: \_\_\_\_\_

Orthodontic Coverage?     Yes     No

**Secondary Dental Insurance**

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone#: \_\_\_\_\_

Group # (plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insured's Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Insured's Employer: \_\_\_\_\_

Orthodontic Coverage?     Yes     No

**CONTINUED ON BACK OF FORM**

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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 their jaw joint (TMJ / TMD)? Yes No

Does the child brush their teeth daily? Yes No

Floss their 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 drugs that the child is currently taking:

\_\_\_\_\_  
\_\_\_\_\_

Please list all drugs that the child is allergic to:

\_\_\_\_\_  
\_\_\_\_\_

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

Y N Heart Murmur

Y N Cancer

Y N Diabetes

Y N Rheumatic Fever

Y N HIV +/- AIDS

Y N Hemophilia

Y N Asthma

Y N Hepatitis

Y N Tuberculosis (TB)

Y N Congenital Heart Defect

Y N Convulsions / Epilepsy

Y N Abnormal Bleeding

Y N Hearing Impairment

Y N Any Operations

Y N Any stays in the hospital

Y N Kidney / Liver Problems

Y N Handicaps / Disabilities

Y N Allergies to any drugs

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

\_\_\_\_\_  
\_\_\_\_\_

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Does the child have any of the following habits?

Y N Thumb / Finger Sucking

Y N Lip Sucking / Biting

Y N Nail Biting

Y N Nursing Bottle Habits

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA.

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I understand that the information that I have given today is correct to the best of my knowledge, that 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 also 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

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: \_\_\_\_\_  
\_\_\_\_\_