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!

1 Tell Us About Your Child

Today's Date: ____________________

Child's Name: ______________________________
Last First M.I.

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

2 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

3 Parent's Information

Who is 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 #): ____________________

4 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

Continued on Back

Dental & Medical History

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

____

____

Has the child ever taken any diet pills such as Phen-Fen? (Also known as Redux or Pondimin.) If so, when? ______ ☐ 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 herbal 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	High Blood Pressure
Y	N	Anemia	Y	N	Hives
Y	N	Any Hospital Stays/Operations?	Y	N	Kidney / Liver Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Low 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/Traits
Y	N	Handicaps/Disabilities	Y	N	Skin Rash
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. ______________________

____

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

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