Welcome

Tell us About Your Child

Today's Date: _____ Child's' Home Phone #: (___)_____

Child's Name: _____ Child's Birthdate: ____ / _____ / _____
Last First MI

Nickname: _____ ❑ Male ❑ Female School: _____ Grade: _____

Child's Home Address: _____
Street City State Zip

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 you? _____ Other Siblings: _____

Neighbor or Relative not Living with You

Name: _____ Relation: _____ Work Phone #: (___)_____ Home Phone #: (___)_____

Address: _____
Street City State Zip

Parent's Information

Parents Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Remarried ❑ Single

Mother: ❑ Step Mother ❑ Guardian Birthdate: ____ / _____ / _____ Cell #: (___)_____ Home Phone #: (___)_____

Name: _____ Social Sec. # _____ Drivers Lic. #: _____

Address: _____
Street City State Zip

Employer: _____ Work # (___)_____ Length of Employment:_____

Father: ❑ Step Father ❑ Guardian Birthdate: ____ / _____ / _____ Cell #: (___)_____ Home Phone #: (___)_____

Name: _____ Social Sec. # _____ Drivers Lic. #: _____

Address: _____
Street City State Zip

Employer: _____ Work # (___)_____ Length of Employment: _____

Person Responsible for Account: _____

Insurance Information

Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (___)_____ Group #(Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street City State Zip

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ____ / _____ / _____ Social Sec. #: _____ Policy Owner's Employer: _____

Employer's Address: _____
Street City State Zip

Is there other Insurance we should be aware of? ❑ Yes ❑ No _____

Dental History

Is the child currently in pain? ❑ Yes ❑ No **What is the primary reason for today's visit?** _____

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

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

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

Does the child brush his / her teeth daily? ❑ Yes ❑ No Floss his / her teeth daily? ❑ Yes ❑ No

Previous / Present Dentist: _____ Date of Last Visit: _____
(Please Circle)

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least about? _____

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

❑ Yes ❑ No	Breast Fed	❑ Yes ❑ No	Mouth Breather	❑ Yes ❑ No	Thumb / Finger Sucking
❑ Yes ❑ No	Chewing on Objects	❑ Yes ❑ No	Nail Biting	❑ Yes ❑ No	Tongue / Cheek Biting
❑ Yes ❑ No	Clenching / Grinding Teeth	❑ Yes ❑ No	Nursing Bottle Habits	❑ Yes ❑ No	Tongue Thrust
❑ Yes ❑ No	Lip Sucking / Biting	❑ Yes ❑ No	Speech Problems	❑ Yes ❑ No	Used Pacifier

CONTINUED ON BACK

Medical History

Child's Physician: _____ Phone #: (____)_____ Date of Last Visit: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? ❑ Yes ❑ No Please explain: _____

Please describe the child's current physical health? ❑ Good ❑ Fair ❑ Poor **Are Immunizations Current?** ❑ Yes ❑ No

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

Has the child had / experienced any of the following:

❑ Yes ❑ No Abnormal Bleeding	❑ Yes ❑ No Epilepsy	❑ Yes ❑ No Measles
❑ Yes ❑ No AIDS / HIV+	❑ Yes ❑ No Handicaps / Disabilities	❑ Yes ❑ No Mitral Valve Prolapse
❑ Yes ❑ No Allergies	❑ Yes ❑ No Hearing Impairment	❑ Yes ❑ No Mononucleosis
❑ Yes ❑ No Anemia	❑ Yes ❑ No Hearth Murmur	❑ Yes ❑ No Psychological Issues
❑ Yes ❑ No Any Hospital Stays / Operations	❑ Yes ❑ No Hemophilia	❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Asthma	❑ Yes ❑ No Hepatitis	❑ Yes ❑ No Scarlet Fever
❑ Yes ❑ No Blood Transfusion	❑ Yes ❑ No High Blood Pressure	❑ Yes ❑ No Sickle Cell Anemia
❑ Yes ❑ No Cancer	❑ Yes ❑ No Hives	❑ Yes ❑ No Skin Rash
❑ Yes ❑ No Chicken Pox	❑ Yes ❑ No Kidney Problems	❑ Yes ❑ No Tonsillitis
❑ Yes ❑ No Congenital Heart Defect	❑ Yes ❑ No Liver Problems	❑ Yes ❑ No Tuberculosis (TB)
❑ Yes ❑ No Convulsions	❑ Yes ❑ No Low Blood Pressure	
❑ Yes ❑ No Diabetes	❑ Yes ❑ No Lupus	

Please discuss any serious medical problems not yet noted. _____

List Medications Child is taking

_____
_____
_____

List of known Drug Allergies

_____
_____
_____

Authorizations

I affirm that the information that I have given is correct to the best of my knowledge. 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. My method of payment will be _____ .

_____
Signature of Parent or guardian Date

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. 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. 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

The parent or guardian who accompanies the child is responsible for payment at time of service.

First Update

Any Changes: _____

_____

_____
Patient's (Parent) Signature Date Reviewed By

Second Update

Any Changes: _____

_____

_____
Patient's (Parent) Signature Date Reviewed By

Third Update

Any Changes: _____

_____

_____
Patient's (Parent) Signature Date Reviewed By