

WELCOME!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The better we communicate, the better we can care for you.

1

Tell Us About Your Child

Today's Date: _____

Child's Name: _____

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 #: (____) _____

DL #: _____ 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 Married Widowed Divorced Separated

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: ____ / ____ / ____ SS #: _____

Policy Owner's Employer: _____

Orthodontic coverage? Yes No

3

Mother's Information Step Mother Guardian

Name: _____ Birthdate: ____ / ____ / ____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Employer: _____

SS #: _____ DL #: _____

Father's Information Step Father Guardian

Name: _____ Birthdate: ____ / ____ / ____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Employer: _____

SS #: _____ DL #: _____

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: ____ / ____ / ____ SS #: _____

Policy Owner's Employer: _____

Orthodontic coverage? Yes No

CONTINUED ON BACK



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 #: _____ Last Visit Date: _____

Is the child currently under the care of a physician? Yes No

Describe the child's current health: Good Fair Poor

Please list all drugs that the child is currently taking:

Please list all drugs/materials that the child is allergic to: _____



Does the child have the following habits?

- Y N Lip Sucking / Biting
- Y N Nail Biting
- Y N Nursing Bottle Habits
- Y N Thumb / Finger Sucking

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



Has the child ever had the following medical problems?

- | | |
|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <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 Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney / Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions / Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |

Please discuss any medical problems that the child has had:



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 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 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

- Date: _____ Signature: _____
Comments: _____
- Date: _____ Signature: _____
Comments: _____
- Date: _____ Signature: _____
Comments: _____