# Welcome

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

Child's Birthdate: ___/___/___ Child's Age: _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Child's Home #: (_____)_____ SS #: _____

Child's Home Address: _____
Apt / Condo #

_____
City State Zip

Email Address: _____

## 2 Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Is child adopted? ☐ Yes ☐ No Is child in a foster home? ☐ Yes ☐ No

Whom may we Thank for referring you? _____

Other siblings seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Parent's Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partnered ☐ Separated

## 3 Parent's Information

**Mother** ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: ___/___/___

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

Employer: _____

SS #: _____ DL #: _____

**Father** ☐ Step Father ☐ Guardian

Name: _____ Birthdate: ___/___/___

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

Employer: _____

SS #: _____ DL #: _____

Neighbor or Relative not living with you.

Name: _____ Phone: (_____)_____

Address: _____

_____
City State Zip

## 4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____
City State Zip

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

Employer: _____

DL #: _____ SS #: _____

### Who is responsible for making appointments?

Name: _____

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

## 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: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

## 6 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: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

CONTINUED ON BACK

## 7 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 #: _____ 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

Has the child ever taken Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin) If yes, when? _____

**Please list all drugs that the child is currently taking:**

_____

_____

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

_____

_____

Latex ☐ Yes ☐ No Metals/Nickel ☐ Yes ☐ No Plastic ☐ Yes ☐ No

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

| | | | |
|---|---|---|---|
| Y N | Abnormal Bleeding | Y N | Handicaps / Disabilities |
| Y N | ADD / ADHD | Y N | Hearing Impairment |
| Y N | Anemia | Y N | Heart Murmur |
| Y N | Any Hospital Stays | Y N | Hemophilia |
| Y N | Any Operations | Y N | Hepatitis |
| Y N | Artificial Bones/Joints/Valves | Y N | Hives |
| Y N | Asthma | Y N | HIV+ / AIDS |
| Y N | Cancer | Y N | Kidney / Liver Problems |
| Y N | Chicken Pox | Y N | Measles |
| Y N | Congenital Heart Defect | Y N | Mononucleosis |
| Y N | Convulsions | Y N | Rheumatic / Scarlet Fever |
| Y N | Diabetes | Y N | Sickle Cell Disease / Traits |
| Y N | Epilepsy | Y N | Skin Rash |
| Y N | Exposed to HIV, but Neg. | 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 that the child has had:** _____

_____

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

Y N Lip Sucking / Biting Y N Nursing Bottle Habits

Y N Nail Biting Y N Thumb / Finger Sucking

Was the child breast fed? ☐ Yes ☐ No

**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.

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 times 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

**1. Date:** _____ **Signature:** _____

**Comments:** _____

_____

**2. Date:** _____ **Signature:** _____

**Comments:** _____

_____