

Welcome

Tell us About Your Child

Today's Date: _____ Child's Home Phone #: (____) _____
Child's Name: _____ Last _____ First _____ MI _____ Child's Birthdate: ____ / ____ / ____
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

Parent's 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 _____
Email Address: _____
Employer: _____ Work # (____) _____ Length of Employment: _____

Father: Step Father Guardian Birthdate: ____ / ____ / ____ Cell #: (____) _____ Home Phone #: (____) _____
Name: _____ Social Sec. # _____ Drivers Lic. #: _____
Address: _____ Street _____ City _____ State _____ Zip _____
Email Address: _____
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?

<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast Fed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth Breather	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thumb / Finger Sucking
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chewing on Objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nail Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tongue / Cheek Biting
<input type="checkbox"/> Yes <input type="checkbox"/> No	Clenching / Grinding Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nursing Bottle Habits	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tongue Thrust
<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip Sucking / Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

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

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