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. We strive to teach good oral care that will enable your child to have a beautiful smile that will last a lifetime.

1	Today's Date:
Child's Name:	Child's Birthday:
Nickname:	☐Female ☐Male
School:	Grade:
Home Ph # ( )	Email address:
Home Address:	

2	Who is accompanying the child today?
Name:	
Relationship:	
Do you have legal custody of this child?	
Whom may we thank for referring you?	
Other siblings seen by us?	
Previous Dentist:	
Last visit date:	
Person Responsible for account	
(Please fill out if different from Parent information)	
Name:	
Relationship:	
Hm ph #: ( )	Wk #: ( )
Address:	
SS #:	DL #:

3	Parents Information	
☐ MOTHER	☐ Stepmother	☐ Guardian
Name:		Birthday:
Wk #: ( )		ext:
Hm #: ( )		Cell Ph
Employer:		
SS #		DL #
☐ FATHER	☐Stepfather	☐Guardian
Name:		Birthday:
Wk #: ( )		ext:
Hm #: ( )		Cell Ph
Employer:		
SS #		DL #
Emergency Contact		
(Neighbor or Relative not living with you.)		
Name:		
Ph #:		
Address:		

4	Primary Dental Insurance	
Ins Co :	Ins Address:	Ins Ph #: ( )
ID # :	Group # :	Subscribers Name:
Birth date:	Subscriber's Employer:	Relationship to patient:
Secondary Dental Insurance		
Ins Co :	Ins Address:	Ins Ph #: ( )
ID # :	Group # :	Subscribers Name:
Birth date:	Subscribers Employer:	Relationship to patient:

Medical History

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 Fosamax, Actonel, Boniva or other bisphosphonate? ☐Yes ☐No

Please list all drugs that the child is currently taking:

Please list any **Allergies** for this child: Latex ☐ Metals/Nickel ☐ Plastic ☐

Has the child 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 list any serious medical problems that the child may have:

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

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

Why did you bring the child in today?

Has the child ever had a serious / difficult problem associated with pervious dental work? ☐Y ☐N

Is the child's water fluoridated? ☐Y ☐N

Is the child taking fluoride supplements? ☐Y ☐N

Has the child ever had pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐Y ☐N

Does the child brush his / her teeth daily? ☐Y ☐N

Floss his / her teeth daily? ☐Y ☐N

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 the 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

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductable 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

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: