

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.

Today's Date: _____

TELL US ABOUT YOUR CHILD

Child's name: _____ Nickname: _____

Birthdate: ____/____/____^{LAST} Age: ____^{FIRST} Male Female SS #: _____

Child's Home Address: _____

Child's Home Phone: _____ School: _____

School: _____

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: Married Partnered Divorced Widowed Separated Single

PARENT'S INFORMATION

MOTHER: Step Mother Guardian Birthdate: _____ Home Phone#: _____

Name: _____ SS#: _____ Driver's Lic.#: _____

Employer: _____ Work Phone #: _____

FATHER: Step Father Guardian Birthdate: _____ Home Phone#: _____

Name: _____ SS#: _____ Driver's Lic.#: _____

Employer: _____ Work Phone #: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____

Home Phone#: _____ Driver Lic. #: _____

Employer: _____ Work Phone #: _____

Who is responsible for making appointments? _____

INSURANCE COVERAGE

Primary

Insurance Co. Name: _____ Insurance Co. Address: _____

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

Policy Owner's Name: _____ Relation: _____

Policy Owner's Birthdate: _____ SS#: _____

Policy Owner's Employer: _____ Employer's Address: _____

Orthodontic Coverage? Yes No

Secondary

Insurance Co. Name: _____ Insurance Co. Address: _____

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

Policy Owner's Name: _____ Relation: _____

Policy Owner's Birthdate: _____ SS#: _____

Policy Owner's Employer: _____ Employer's Address: _____

Orthodontic Coverage? Yes No

CHILD'S MEDICAL HISTORY

Has the child ever had any of the following diseases or medical problems?

- | | | |
|----------------------------|-----------------------------|-----------------------------|
| Y N Abnormal bleeding | Y N Chicken Pox | Y N Heart Murmur |
| Y N Allergies to any drugs | Y N Congenital Heart Defect | Y N Hemophilia |
| Y N Any Hospital Stays | Y N Convulsions/Epilepsy | Y N HIV+ / AIDS |
| Y N Any Operations | Y N Diabetes | Y N Kidney/Liver Problems |
| Y N Asthma | Y N Handicaps/Disabilities | Y N Rheumatic/Scarlet Fever |
| Y N Cancer | Y N Hearing Impairment | Y N Tuberculosis (TB) |

Child's Physician: _____

Phone #: _____ Last Visit Date: _____

Child's current physical health is: Good Fair Poor Is child currently under the care of a physician? Yes No

Is child taking any prescription or over-the counter drugs? Yes No

Please list each one: _____

Please list any drugs/materials child is allergic to: _____

Why did you bring the child to the dentist today? _____

Have the child ever had a serious/difficult problem associated with any previous dental work? Yes No

Has the child now or ever experienced pain or discomfort in the jaw joint? (TMJ or TMD) Yes No

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Does the child brush daily? Yes No

Does the child floss daily? Yes No

Does the child have any of 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 HIPAA compliant and is committed to meeting or exceeding the standards of infections control mandated by OSHA, the CDC, and the ADA.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in 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 any necessary dental services that my child may need.

Signature _____

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

I verbally reviewed the medical/dental information above with the patient. Initials: _____ Date: _____

Doctor's comments: _____

Medical History Updates:

Date: _____ Comments: _____ Signature: _____

Date: _____ Comments: _____ Signature: _____

Date: _____ Comments: _____ Signature: _____