# 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

Nickname: _____ ☐ Male ☐ Female

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

School: _____ Grade: _____

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

E-mail Address: _____

**Child's Home Address:**

_____
APT/CONDO #

_____
CITY STATE ZIP

## 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 ☐ Widowed ☐ Partnered ☐ Married ☐ Divorced ☐ Separated

## 3 ☐ Mother's Information: ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: __/__/__

Hm #: (____)_____ Cell #: (____)_____

Employer: _____ Wk #: (____)_____

SS #: _____ DL #: _____

## ☐ Father's Information: ☐ Step Father ☐ Guardian

Name: _____ Birthdate: __/__/__

Hm #: (____)_____ Cell #: (____)_____

Employer: _____ Wk #: (____)_____

SS #: _____ DL #: _____

## 4 Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

Hm #: (____)_____ DL #: _____

Employer: _____

Wk #: (____)_____ Ext: ____ 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: __/__/__ ID#: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

## 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: __/__/__ ID#: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

CONTINUED ON BACK

## 6 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 your child ever taken Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin) If so, when? _____

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

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

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

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

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding | Y | N | Diabetes |
| Y | N | ADD/ADHD | Y | N | Handicaps / Disabilities |
| Y | N | Allergies to any drugs | Y | N | Hearing Impairment |
| Y | N | Any Hospital Stays | Y | N | Heart Murmur |
| Y | N | Any Operations | Y | N | Hemophilia |
| Y | N | Artificial Bones / Joints / Valves | Y | N | Hepatitis |
| | | | Y | N | HIV+ / AIDS |
| Y | N | Asthma | Y | N | Kidney / Liver Problems |
| Y | N | Cancer | Y | N | Rheumatic / Scarlet Fever |
| Y | N | Congenital Heart Defect | Y | N | Sickle Cell Disease / Traits |
| Y | N | Convulsions / Epilepsy | Y | N | Tuberculosis (TB) |

Please discuss any serious medical problems that the child has had:
_____
_____
_____

## 8 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 |

**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.**

Neighbor or Relative not living with you.
Name: _____ Phone: (____)_____
Address: _____
_____
CITY STATE ZIP

## 9

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** **Date**

**The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.**

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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: _____
_____