

# 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 #: \_\_\_\_\_

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

Whom may we Thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_  
(Please Circle)

Last Visit Date: \_\_\_\_\_

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

## 3 Mother's Information: Step Mother Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Email Address: \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Wk #: (\_\_\_\_) \_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

## Father's Information: Step Father Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Email Address: \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Wk #: (\_\_\_\_) \_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

## 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: \_\_\_\_/\_\_\_\_/\_\_\_\_ ID #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

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: \_\_\_\_\_

Orthodontic Coverage?  Yes  No

**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 the child ever taken Phen-Fen?  Yes  No

(Also known as Redux or Pondimin) If so, when? \_\_\_\_\_

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking:

\_\_\_\_\_

\_\_\_\_\_

Aside from items below, 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 Handicaps / Disabilities
Y N ADD / ADHD	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	Y N Hepatitis
Y N Asthma	Y N HIV+ / AIDS
Y N Cancer	Y N Kidney / Liver Problems
Y N Congenital Heart Defect	Y N Rheumatic / Scarlet Fever
Y N Convulsions / Epilepsy	Y N Sickle Cell Disease / Traits
Y N Diabetes	Y N Tuberculosis (TB)

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

\_\_\_\_\_

\_\_\_\_\_

**8**

Does/did the child experience any of the following?

Y N Lip Sucking / Biting	Y N Mouth Breather
Y N Speech Problems	Y N Tongue Thrust
Y N Nail Biting	Y N Nursing Bottle Habits
Y N Thumb / Finger Sucking	Y N Clenching / Grinding Teeth

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.

**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 of parent or guardian

\_\_\_\_\_  
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 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: \_\_\_\_\_

\_\_\_\_\_