

# 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.

## 1

### Tell Us About Your Child

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Nickname: \_\_\_\_\_ ☐ Male ☐ Female

Child's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Child's Home #: (\_\_\_\_) \_\_\_\_\_ SS #: \_\_\_\_\_

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 ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

## 3

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

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

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

Employer: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ SS #: \_\_\_\_\_

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

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

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

Employer: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ SS #: \_\_\_\_\_

## 4

### Person Responsible For Account

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

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

#### Who is responsible for making appointments?

Name: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

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### 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

CONTINUED ON BACK





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### Has the child ever had the following medical problems?

- |                             |                               |
|-----------------------------|-------------------------------|
| Y N Abnormal Bleeding       | 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 Asthma                  | Y N Hepatitis                 |
| Y N Cancer                  | Y N HIV+ / AIDS               |
| Y N Congenital Heart Defect | Y N Kidney / Liver Problems   |
| Y N Convulsions / Epilepsy  | Y N Rheumatic / Scarlet Fever |
| Y N Diabetes                | Y N Tuberculosis (TB)         |

Please discuss any medical problems that the child has had:

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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.

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

Is the child currently under the care of a physician? ☐ Yes ☐ No

Describe the child's current health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:

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

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### Does the child have 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 infection control mandated by OSHA, the CDC and the ADA.

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: \_\_\_\_\_

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### Medical History Update

1. Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Comments: \_\_\_\_\_

2. Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Comments: \_\_\_\_\_

3. Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Comments: \_\_\_\_\_

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