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

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

Nickname: ______________________ ☐ Male ☐ Female

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

Is child adopted? ☐ Yes ☐ No Is child in a foster home? ☐ Yes ☐ No

Whom may we Thank for referring you?______________________

Other siblings seen by us: ______________________________

Previous / Present Dentist: ______________________________
(Please Circle)

Last Visit Date: ______________________________

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

3 Parent's Information

☐ **Mother** ☐ Step Mother ☐ Guardian

Name: ______________________ Birthdate: ___/___/___

Wk #: (_____)__________ Ext: ______ Hm #:(_____)__________

Employer: ______________________________

SS #: ____________________ DL #: ______________

☐ **Father** ☐ Step Father ☐ Guardian

Name: ______________________ Birthdate: ___/___/___

Wk #: (_____)__________ Ext: ______ Hm #:(_____)__________

Employer: ______________________________

SS #: ____________________ DL #: ______________

Neighbor or Relative not living with you.

Name: ____________________ Phone:(_____)__________

Address: ______________________________

____
City State Zip

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: ______________________________

Employer's Address: ______________________________

Orthodontic Coverage? ☐ Yes ☐ No

6 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

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

Please list all drugs that the child is currently taking:

____

____

Aside from items listed below, list all drugs/things the child is allergic to:

____

____

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

8 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	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 discuss any serious medical problems that the child has had: ______________________

____

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

Was the child breast fed? ☐ Yes ☐ No

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.

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 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.

My method of payment will be: ______________________

Signature of parent or guardian ______________________ Date

I certify that my child is covered by ______________________ Insurance Co. and I assign directly to Dr. ______________________ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible 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

The Parent or Guardian who accompanies the child is responsible for payment at times 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: ______________________

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