Welcome

We would like to welcome 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: _____

Hobbies: _____

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

Child's Home Address: _____
Apt / Condo #

_____
City   State   Zip

2 General Information

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 siblings: _____

Previous / Present Dentist: _____   Last Visit Date: _____

Dentist's Phone #: (____)_____

Relative or Friend not living with you:

Name: _____   Phone: (____)_____

Address: _____

_____
City   State   Zip

3 Parent's Information

Person Responsible for Account: _____

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

☐ **Mother** ☐ **Father** ☐ **Step Parent** ☐ **Guardian**	☐ **Mother** ☐ **Father** ☐ **Step Parent** ☐ **Guardian**
Name: _____ Birthdate:___/___/___	Name: _____ Birthdate:___/___/___
Address: (If different than Child's) Hm #: (____)_____	Address: (If different than Child's) Hm #: (____)_____
_____	_____
SS #: _____ DL #: _____	SS #: _____ DL #: _____
Wk #: (____)_____ Ext: _____ Cell/Other #: (____)_____	Wk #: (____)_____ Ext: _____ Cell/Other #: (____)_____
Email: _____	Email: _____
Employer: _____	Employer: _____
Employer's Address: _____	Employer's Address: _____
_____ City State Zip	_____ City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____	Insurance Co. Name: _____
Insurance Address: _____	Insurance Address: _____
_____ City State Zip	_____ City State Zip
Insurance Phone: (____)_____	Insurance Phone: (____)_____
Group # (Plan, Local, or Policy #): _____	Group # (Plan, Local, or Policy #): _____

4 Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits other wise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment 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

5 Dental History

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

Has the child ever taken Fosamax or any other ☐ Yes ☐ No
  bisphosphonate? If so, when? _____

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

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

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

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

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

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

6 Medical History

Has the child experienced the following medical problems?

Y N Abnormal Bleeding / Hemophilia	Y N Hearing Impairment
Y N ADD/ADHD	Y N Heart Murmur
Y N AIDS/HIV+	Y N Hepatitis
Y N Anemia	Y N High Blood Pressure
Y N Any Hospital Stays/Operations?	Y N Hives
Y N Artificial Bones/Joints/Valves	Y N Kidney Problems
Y N Asperger Syndrome	Y N Liver Problems
Y N Asthma	Y N Low Blood Pressure
Y N Autism	Y N Lupus
Y N Cancer	Y N Measles
Y N Chicken Pox	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Mononucleosis
Y N Convulsions	Y N Prosthetics
Y N Diabetes	Y N Rheumatic Fever
Y N Epilepsy	Y N Scarlet Fever
Y N Exposed to HIV, but Neg.	Y N Skin Rash
Y N Handicaps/Disabilities	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 the child experiences/ed:
_____
_____

Does/did the child experience any of the following?

Y N Breast Fed	Y N Nursing Bottle Habits
Y N Chewing on Objects	Y N Speech Problems
Y N Clenching/Grinding Teeth	Y N Thumb/Finger Sucking
Y N Lip Sucking/Biting	Y N Tongue/Cheek Biting
Y N Mouth Breather	Y N Tongue Thrust
Y N Nail Biting	Y N Used Pacifier

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.

_____   _____
Signature of Parent or Guardian   Date

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. _____

Parent/Guardian Signature	Date
Dentist Signature	Date

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. _____

Parent/Guardian Signature	Date
Dentist Signature	Date