WELCOME TO THE DENTIST

Our goal is to help your child reach and maintain good oral health and a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: ________________

Child's Name: ________________ (LAST) ________________ (FIRST) ____ (MI)

Nickname: ________________ ☐M ☐F

Birthdate: ___/___/___ Age: ____ SS #: ________________

School: ________________ Grade: ______

Hobbies / Sports: ________________

Child's Home # (_____) ________________

Child's Home Address: ________________

________________ (CITY) ________________ (STATE) ________ (ZIP)

2 Who is Accompanying Your Child Today?

Name: ________________ Relation: ________________

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

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? ________________

List other family members seen by us ________________

____

Previous Dentist: ________________

Date of last cleaning / visit: ________________

3 Parental Information

☐ **Mother** ☐ Stepmother ☐ Guardian

Name: ________________ Birthdate ___/___/___

Wk # (_____) ________________ Hm # (_____) ________________

Employer: ________________

How long at current job: ________ Job Title: ________________

SS #: ________________ DL #: ________________

☐ **Father** ☐ Stepfather ☐ Guardian

Name: ________________ Birthdate ___/___/___

Wk # (_____) ________________ Hm # (_____) ________________

Employer: ________________

How Long at Current Job: ________ Job Title: ________________

SS #: ________________ DL #: ________________

4 Person Responsible for Account

Name: ________________ Relation: ________________

Billing Address: ________________

________________ (CITY) ________________ (STATE) ________ (ZIP)

Previous Address: ________________

Hm # (_____) ________________ DL #: ________________

Employer: ________________

Wk # (_____) ________________ SS #: ________________

Who is responsible for making appointments?

Name: ________________

Wk # (_____) ________________ Hm # (_____) ________________

E-mail Address: ________________

5 Primary Dental Insurance

Dental Coverage? ☐Y ☐N Orthodontic Coverage? ☐Y ☐N

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: ________________

Secondary Dental Insurance

Dental Coverage? ☐Y ☐N Orthodontic Coverage? ☐Y ☐N

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: ________________

CONTINUED ON BACK

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Why did you bring your child to the dentist today? ______

Has your child ever been evaluated or had dental treatment before? ☐Y ☐N

Has your child ever had a serious / difficult problem associated with previous dental work? ☐Y ☐N

Have there been any injuries to the face, mouth, teeth or chin? ☐Y ☐N

List any musical instruments played: ______

Have adenoids or tonsils been removed? ☐Y ☐N

Has your child been informed of any missing or extra permanent teeth? ☐Y ☐N

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐Y ☐N

Does your child brush his / her teeth daily? ☐Y ☐N

Does your child floss his / her teeth daily? ☐Y ☐N

Child's Physician: ______

Phone # (____)______ Date of last visit:______

Is your child under the care of a physician? ☐Y ☐N

Has puberty begun? ☐Y ☐N

Girls - Has menstruation begun? ☐Y ☐N

Please describe your child's current physical health: ☐Good ☐Fair ☐Poor

Please list all drugs that your child is currently taking:

______ ______

Please list all drugs/things that your child is allergic to:

______ ______

Latex Y N Metals / Nickel Y N Plastics Y N

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

Y N Abnormal Bleeding
Y N ADD / ADHD
Y N Allergies to Any Drugs
Y N Allergic to Latex / Metals
Y N Allergic to Plastic
Y N Any Hospital Stays
Y N Any Operations
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions / Epilepsy
Y N Diabetes
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV+ / AIDS
Y N Kidney / Liver Problems
Y N Lupus
Y N Rheumatic / Scarlet Fever
Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had:

______
______
______

8 Has your child ever experienced any of the following?

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

Neighbor or Relative not living with you

Name______ Ph # (____)______

Address ______

CITY STATE ZIP

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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 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 that my child may need.

______
SIGNATURE OF PARENT OR GUARDIAN DATE

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

______
SIGNATURE OF PARENT OR GUARDIAN DATE

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

______
SIGNATURE OF PARENT OR GUARDIAN DATE

The Parent or Guardian who accompanies the child is responsible for payment.
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

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Doctor's Comments: ______ Initials: ______ Date: ______

______

MEDICAL HISTORY UPDATE

I have read my history dated ______ and confirmed that it states past and present conditions. ______
SIGNATURE DATE

I have read my history dated ______ and confirmed that it states past and present conditions. ______
SIGNATURE DATE

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