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: __/__/__

Email Address: ____________

Cell #: (____) ____________ Hm #: (____) ____________

Employer: ____________ Wk #: (____) ____________

SS #: ____________ DL #: ____________

☐ **Father** ☐ 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: ____________

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 ADD / ADHD
Y N Anemia
Y N Any Hospital Stays
Y N Any Operations
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Exposed to HIV, but Neg.
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Hives
Y N HIV+ / AIDS
Y N Kidney / Liver Problems
Y N Measles
Y N Mononucleosis
Y N Rheumatic / Scarlet Fever
Y N Sickle Cell Disease / Traits
Y N Skin Rash
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 experience any of the following?

Y N Lip Sucking / Biting
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Thumb / Finger Sucking

Was the child breast fed? n Yes n 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.

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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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