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

2 Who Is Accompanying the Child Today?

Name: _____ Relation: _____

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

Is the child adopted? ☐ Yes ☐ No

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

Whom may we Thank for referring you? _____

Other siblings seen by us: _____

Previous/Present Dentist: _____
Please circle one

Last Visit Date: _____

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

_____

4 Dental History

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

Has the child ever had any pain/tenderness in His/her jaw joint (TMJ/TMD) ☐ Yes ☐ No

Does the child brush teeth daily? ☐ Yes ☐ No

Floss teeth daily? ☐ Yes ☐ No

Does/did child have any of the following habits? (please circle)

Lip Sucking/Biting Nursing Bottle Habits

Nail biting Thumb/Finger sucking

Was Child breast fed? ☐ Yes ☐ No

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: ___/___/___ SS#: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

6 Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurqnce Co. Phone #: (___) _____

Group # (Plan,Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ SS#: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

Medical History

PATIENT NAME: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No	If Yes, _____
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If Yes, _____
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If Yes, _____
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If Yes, _____
Are you on a special diet?	☐ Yes	☐ No	

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Local Anesthetics ○ Other _____

Do you have, or have you had any of the following?

☐ Anaphylaxis	☐ Cold Sores/Fever Blisters	☐ Glaucoma	☐ Kidney Problems	☐ Scarlet Fever
☐ Anemia	☐ Congenital Heart Disorder	☐ Hay Fever	☐ Leukemia	☐ Shingles
☐ Angina	☐ Convulsions	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Cortisone Medicine	☐ Heart Murmur*	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valve*	☐ Diabetes	☐ Heart Pace Maker*	☐ Lung Disease	☐ Spina Bifida
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse*	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Pain in Jaw Joints	☐ Stroke
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Parathyroid Disease	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Psychiatric Care	☐ Thyroid Disease
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Radiation Treatments	☐ Tonsillitis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Recent Weight Loss	☐ Tuberculosis
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Renal Dialysis	☐ Tumors or Growths
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatic Fever*	☐ Ulcers
☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heart beat	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No ☐ N/A _____

Comments: _____

_____

_____

*Conditions may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Signature of Parent Date