

# 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.

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## 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: \_\_\_\_\_

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## 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  Widowed  Partnered  
 Married  Divorced  Separated

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## 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

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## 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 #: (\_\_\_\_) \_\_\_\_\_

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## 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

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## 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

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### 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)?

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:

Has the child ever taken Fosamax, Actonel, Boniva or any other bisphosphonate?  Good  Fair  Poor  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

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### Has the child ever had any of the following medical problems?

- |                            |                            |                                |                            |                            |                              |
|----------------------------|----------------------------|--------------------------------|----------------------------|----------------------------|------------------------------|
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Abnormal Bleeding              | <input type="checkbox"/> Y | <input type="checkbox"/> N | Handicaps / Disabilities     |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | ADD / ADHD                     | <input type="checkbox"/> Y | <input type="checkbox"/> N | Hearing Impairment           |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Anemia                         | <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart Murmur                 |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Any Hospital Stays             | <input type="checkbox"/> Y | <input type="checkbox"/> N | Hemophilia                   |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Any Operations                 | <input type="checkbox"/> Y | <input type="checkbox"/> N | Hepatitis                    |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Artificial Bones/Joints/Valves | <input type="checkbox"/> Y | <input type="checkbox"/> N | Hives                        |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Asthma                         | <input type="checkbox"/> Y | <input type="checkbox"/> N | HIV+ / AIDS                  |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Cancer                         | <input type="checkbox"/> Y | <input type="checkbox"/> N | Kidney / Liver Problems      |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Chicken Pox                    | <input type="checkbox"/> Y | <input type="checkbox"/> N | Measles                      |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Congenital Heart Defect        | <input type="checkbox"/> Y | <input type="checkbox"/> N | Mononucleosis                |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Convulsions                    | <input type="checkbox"/> Y | <input type="checkbox"/> N | Rheumatic / Scarlet Fever    |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Diabetes                       | <input type="checkbox"/> Y | <input type="checkbox"/> N | Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Epilepsy                       | <input type="checkbox"/> Y | <input type="checkbox"/> N | Skin Rash                    |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Exposed to HIV, but Neg.       | <input type="checkbox"/> Y | <input type="checkbox"/> 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?

- |                            |                            |                      |                            |                            |                        |
|----------------------------|----------------------------|----------------------|----------------------------|----------------------------|------------------------|
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Lip Sucking / Biting | <input type="checkbox"/> Y | <input type="checkbox"/> N | Nursing Bottle Habits  |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Nail Biting          | <input type="checkbox"/> Y | <input type="checkbox"/> 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.**

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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: \_\_\_\_\_