

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 #

Email Address: _____
City State Zip

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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

Parent: Mother Father Step Parent Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

Cell #: (____) _____ Hm #: (____) _____

Employer: _____ Wk #: (____) _____

SS #: _____ DL #: _____

Parent: Mother Father Step Parent Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

Cell #: (____) _____ Hm #: (____) _____

Employer: _____ Wk #: (____) _____

SS #: _____ DL #: _____

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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

CONTINUED ON BACK

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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)? 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

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

- | | | | |
|---|----------------------|---|------------------------|
| <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: _____