

Welcome! The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Today's Date: \_\_\_\_\_

## TELL US ABOUT YOUR CHILD

**Child's name:** \_\_\_\_\_ **Nickname:** \_\_\_\_\_

**Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_ LAST **Age:** \_\_\_\_ FIRST ☐ Male ☐ Female MI **SS #:** \_\_\_\_\_

**Child's Home Address:** \_\_\_\_\_

**Child's Home Phone:** \_\_\_\_\_ **School:** \_\_\_\_\_

**School:** \_\_\_\_\_

## WHO IS ACCOMPANYING THE CHILD TODAY?

**Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

Do you have legal custody of this child? ☐ Yes ☐ No Whom may we thank for referring you?

Other family members seen by us: \_\_\_\_\_

**Previous/Present Dentist:** \_\_\_\_\_

Last visit date: \_\_\_\_\_

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

## PARENT'S INFORMATION

**MOTHER:** ☐ Step Mother ☐ Guardian **Birthdate:** \_\_\_\_\_ **Home Phone#:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **Driver's Lic. #:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone #:** \_\_\_\_\_

**FATHER:** ☐ Step Father ☐ Guardian **Birthdate:** \_\_\_\_\_ **Home Phone#:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **Driver's Lic. #:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone #:** \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT

**Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Billing Address:** \_\_\_\_\_

**Home Phone#:** \_\_\_\_\_ **Driver Lic. #:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone #:** \_\_\_\_\_

**Who is responsible for making appointments?** \_\_\_\_\_

## INSURANCE COVERAGE

### Primary

**Insurance Co. Name:** \_\_\_\_\_ **Insurance Co. Address:** \_\_\_\_\_

**Insurance Co. Phone #:** \_\_\_\_\_ **Group # (Plan, Local or Policy#):** \_\_\_\_\_

**Policy Owner's Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Policy Owner's Birthdate:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Policy Owner's Employer:** \_\_\_\_\_ **Employer's Address:** \_\_\_\_\_

**Orthodontic Coverage?** ☐ Yes ☐ No

### Secondary

**Insurance Co. Name:** \_\_\_\_\_ **Insurance Co. Address:** \_\_\_\_\_

**Insurance Co. Phone #:** \_\_\_\_\_ **Group # (Plan, Local or Policy#):** \_\_\_\_\_

**Policy Owner's Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Policy Owner's Birthdate:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Policy Owner's Employer:** \_\_\_\_\_ **Employer's Address:** \_\_\_\_\_

**Orthodontic Coverage?** ☐ Yes ☐ No

## CHILD'S MEDICAL HISTORY

Has the child ever had any of the following diseases or medical problems?

Y N Abnormal bleeding  
Y N Allergies to any drugs  
Y N Any Hospital Stays  
Y N Any Operations  
Y N Asthma  
Y N Cancer

Y N Chicken Pox  
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 HIV+ / AIDS  
Y N Kidney/Liver Problems  
Y N Rheumatic/Scarlet Fever  
Y N Tuberculosis (TB)

Child's Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

Child's current physical health is: ☐ Good ☐ Fair ☐ Poor Is child currently under the care of a physician? ☐ Yes ☐ No

Is child taking any prescription or over-the counter drugs? ☐ Yes ☐ No

Please list each one: \_\_\_\_\_

Please list any drugs/materials child is allergic to: \_\_\_\_\_

Why did you bring the child to the dentist today? \_\_\_\_\_

Have the child ever had a serious/difficult problem associated with any previous dental work? ..... ☐ Yes ☐ No

**Has the child now or ever experienced pain or discomfort in the jaw joint? (TMJ or TMD)** ..... ☐ Yes ☐ No

Is the child's water fluoridated? ..... ☐ Yes ☐ No

Is the child taking fluoride supplements? ..... ☐ Yes ☐ No

Does the child brush daily? ..... ☐ Yes ☐ No

Does the child floss daily? ..... ☐ Yes ☐ No

**Does the child have any of the following habits?**

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

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infections control mandated by OSHA, the CDC, and the ADA.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in 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 any necessary dental services that my child may need.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.**

### OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's comments: \_\_\_\_\_

### Medical History Updates:

Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_