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: _____ (LAST / FIRST / MI) Nickname: _____

Birthdate: ___/___/___ Age: _____ ❑ Male ❑ Female 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: _____