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)

Nickname: ____________________ ☐ Male ☐ Female

Child's Birthdate: ____/____/____ Child's Age: ________

School: ____________________ Grade: ________

Child's Home #: (____)__________ SS #: __________

Child's Home Address:

____________________ APT /CONDO #

____________________ CITY / STATE / ZIP

Email Address: ____________________

2 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: ____________________
(Please Circle)

Last Visit Date: ____________________

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

3

☐ **Mother's Information:** ☐ Step Mother ☐ Guardian

Name: ____________________ Birthdate: ___/___/___

Email Address: ____________________

Cell #: (____)__________ Hm #: (____)__________

Employer: ____________________ Wk #: (____)__________

SS #: ____________________ DL #: __________

☐ **Father's Information:** ☐ Step Father ☐ Guardian

Name: ____________________ Birthdate: ___/___/___

Email Address: ____________________

Cell #: (____)__________ Hm #: (____)__________

Employer: ____________________ Wk #: (____)__________

SS #: ____________________ DL #: __________

4 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 #: (____)________

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: ___/___/___ ID #: __________

Policy Owner's Employer: ____________________

Orthodontic Coverage? ☐ Yes ☐ No

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: ____________________

Orthodontic Coverage? ☐ Yes ☐ No

CONTINUED ON BACK

6 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 Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin) If so, when? ______

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking:

____

____

Aside from items below, list all drugs/materials that the child is allergic to:

____

____

Latex? ☐ Yes ☐ No Metals/Nickel? ☐ Yes ☐ No Plastic? ☐ Yes ☐ No

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

Y N Abnormal Bleeding
Y N ADD / ADHD
Y N Any Hospital Stays
Y N Any Operations
Y N Artificial Bones / Joints
Y N Asthma
Y N Cancer
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 Hepatitis
Y N HIV+ / AIDS
Y N Kidney / Liver Problems
Y N Rheumatic / Scarlet Fever
Y N Sickle Cell Disease / Traits
Y N Tuberculosis (TB)

Please discuss any serious medical problems that the child has had: ____________

____

____

8 Does/did the child experience any of the following?

Y N Lip Sucking / Biting
Y N Speech Problems
Y N Nail Biting
Y N Thumb / Finger Sucking
Y N Mouth Breather
Y N Tongue Thrust
Y N Nursing Bottle Habits
Y N Clenching / Grinding Teeth

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.

9

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of 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.

____
Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at time 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: ____________

____

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