Welcome!

We would like to welcome your child to our office. Our goal is to make every 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!

Date: _____

Child's Name: Last_____First_____MI____

Child's Birthdate _____/_____/_____ Child's Age:_____ Nickname:_____ M or F

Child's Home Address _____City_____State_____Zip_____

Child's Home #: (_____)_____ Cell # _____Email_____

School:_____ Grade:_____Hobbies_____

Who is/will be Accompanying the Child?

Name _____ Relation:_____ Do you have legal custody of this child Y N

Other siblings_____ Previous Dentist_____

Last visit date_____

PARENT/GUARDIAN INFORMATION:

Person Responsible for Account _____ Phone #_____

Billing Address: _____

Parent's Marital Status Single Married Partnered Widowed Divorced Separated

___Father ___ Step Father ___ Guardian

Name_____ Birthdate:____/___/____ SS#_____

Address:_____ DL#_____

Phone: Home _____ Cell _____ Work_____Ext_____

Email:_____ Employer_____

___ Mother ___ Step Mother ___ Guardian

Name_____ Birthdate:____/___/____ SS#_____

Address:_____ DL#_____

Phone: Home _____ Cell _____ Work_____Ext_____

Email:_____ Employer_____

Primary Dental Insurance: Insurance Co. Name_____ Phone #_____

Ins Co. Address:_____ Group #_____ ID#_____

Policy Owner Name _____ Employer_____ Birthdate _____

Secondary Dental Insurance: Insurance Co. Name_____ Phone #_____

Ins Co. Address:_____ Group #_____ ID#_____

Policy Owner Name _____ Employer_____ Birthdate _____

DENTAL HISTORY

Why did you bring the child to the dentist today?_____

Does the child brush his/her teeth daily? Yes No Does the child floss his/her teeth daily? Yes No

Is this the child's first dental visit? Yes No Previous Dentist_____

Has the child seen an orthodontist? Yes No Name of orthodontist _____

Has the child ever had difficulty with previous dental treatment? Yes No Explain_____

Is the child's water fluoridated? Yes No Does the child take Fluoride supplements Yes No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Does the child require antibiotics before dental treatment Yes No

Is the child allergic to: Latex? Y N Metals/Nickel? Y N Plastic? Y N

Please list all drugs/material that the child is allergic to:_____

_____

Does/did the child experience any of the following?

Y N Speech problems Y N Clenching/grinding teeth Y N Thumb/finger sucking

MEDICAL HISTORY

Please describe child's overall health Good Fair Poor

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

Y N Abnormal Bleeding Y N ADD/ADHD Y N AIDS/HIV+ Y N Anemia Y N Asthma

Y N Artificial Bones/Valves Y N Operations Y N Hospital Stays Y N Cancer Y N Diabetes

Y N Congenital Heart Defect Y N Convulsions Y N Epilepsy Y N Heart murmur Y N Hemophilia

Y N Hepatitis Y N Handicaps/Disabilities Y N Kidney/Liver problems

Please discuss any serious medical problems the child has/had:_____

_____

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

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 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.

I understand that I am fully responsible for any payment due at the time of service. I understand that if the child is covered by dental insurance I am responsible for any balance due for all services rendered.

_____

Signature of Parent or Guardian Date