

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.



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 #: _____

E-mail Address: _____

Child's Home Address: _____
CITY STATE ZIP APT/CONDO #



Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____
CITY STATE ZIP

Hm #: (____) _____ DL #: _____

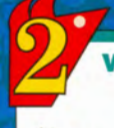
Employer: _____

Wk #: (____) _____ Ext: ____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____) _____ Ext: ____ Hm #: (____) _____



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: Single Widowed Partnered
 Married Divorced Separated



Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

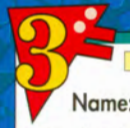
Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ ID#: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? Yes No



Mother's Information: Step Mother Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

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

Employer: _____ Wk #: (____) _____

SS #: _____ DL #: _____

Father's Information: Step Father Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

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

Employer: _____ Wk #: (____) _____

SS #: _____ DL #: _____

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

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 your child ever taken Fosamax, or any other bisphosphonate? Yes No

Has your child ever taken Phen-Fen? Yes No

Please list all drugs that the child is currently taking: _____

Please 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?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <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 Allergies to any drugs | <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 Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney / Liver Problems |
| <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 / Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |

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

8

Does/did the child have any of the following habits?

- | | |
|--|--|
| <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 |

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.

Neighbor or Relative not living with you.

Name: _____ Phone: (____) _____

Address: _____

CITY STATE ZIP

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 _____ 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 OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

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: _____