Welcome!

Tell Us About Your Child

Today's Date: _____ Child's Home Phone #: (____)_____ Social Security #: _____

Child's Name: _____ Child's Birthdate: ____/____/____ Child's Age: _____
Last First MI

Nickname: _____ ❑ Male ❑ Female School: _____ Grade: _____

Child's Home Address: _____
Street City State Zip

Whom may we thank for referring you? _____

Email Address: _____

Parent's Information

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

Parent: ❑ Mother ❑ Father ❑ Step Parent ❑ Guardian

Name: _____ Social Security #: _____ Driver's License #: _____

Birthdate: ____/____/____ Home Phone #: (____)_____ Work Phone #: (____) _____

Email Address: _____ Cell #: (____) _____

Address: _____
Street City State Zip

Employer: _____ Length of Employment: _____

Parent: ❑ Father ❑ Mother ❑ Step Parent ❑ Guardian

Name: _____ Social Security #: _____ Driver's License #: _____

Birthdate: ____/____/____ Home Phone #: (____)_____ Work Phone #: (____) _____

Email Address: _____ Cell #: (____) _____

Address: _____
Street City State Zip

Employer: _____ Length of Employment: _____

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
PO Box/Street City State Zip

Insured's Name: _____ Relationship to Patient: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____ Insured's Employer: _____

Employer's Address: _____
Street City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
PO Box/Street City State Zip

Insured's Name: _____ Relationship to Patient _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____ Insured's Employer: _____

Employer's Address: _____
Street City State Zip

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Dental History

Is the child currently in pain? ❑ **Yes** ❑ **No** **What is the primary reason for today's visit?** _____

Has the child experienced problems with previous dental work? ❑ Yes ❑ No

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

Floss his / her teeth daily? ❑ Yes ❑ No

Previous / Present Dentist: _____ Date of Last Visit _____
(Please Circle)

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least? _____

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

Y N Lip Sucking/Biting	Y N Clenching/Grinding Teeth	Y N Tongue/Cheek Biting	Y N Mouth Breather
Y N Nail Biting	Y N Thumb/Finger Sucking	Y N Used Pacifier	Y N Speech Problems
Y N Chewing on Objects	Y N Nursing Bottle Habits	Y N Tongue Thrust	Y N Breast Fed

Medical History

Child's Physician: _____ Phone #: (____)_____ Date of last visit: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? ❑ Yes ❑ No Please explain: _____

Please describe the child's current physical health: ❑ Good ❑ Fair ❑ Poor **Are Immunizations Current?** ❑ Yes ❑ No

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

Besides the following, please list all drugs and/or things that cause the child allergic reactions:

Latex? ❑ Yes ❑ No Metals/Nickel ❑ Yes ❑ No Plastic? ❑ Yes ❑ No Penicillin? ❑ Yes ❑ No Tetracycline? ❑ Yes ❑ No

_____

_____

Anything you would like to discuss with the Doctor in private? ❑ Yes ❑ No

Has the child had/experienced any of the following:

Y N Abnormal Bleeding	Y N Cancer	Y N Hemophilia	Y N Mitral Valve Prolapse
Y N AIDS/HIV+	Y N Chicken Pox	Y N Hepatitis	Y N Mononucleosis
Y N Allergies	Y N Congenital Heart Defect	Y N High Blood Pressure	Y N Rheumatic Fever
Y N Anemia	Y N Convulsions	Y N Hives	Y N Scarlet Fever
Y N Any Hospital Stay/Operations	Y N Diabetes	Y N Kidney Problems	Y N Sickle Cell Anemia
Y N Asperger's Syndrome	Y N Epilepsy	Y N Liver Problems	Y N Skin Rash
Y N Asthma	Y N Handicaps/Disabilities	Y N Low Blood Pressure	Y N Tonsillitis
Y N Autism	Y N Hearing Impairment	Y N Lupus	Y N Tuberculosis (TB)
Y N Blood Transfusion	Y N Heart Murmur	Y N Measles	

Please discuss any serious medical problems the child experiences/ed: _____

_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that 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 services that my child may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

_____ _____
Signature Date