WELCOME

1 Tell us about your child

Today's Date ____________

Child's Name: ____________________
Last First MI

He/She prefers to be called: ____________ ☐**Male** ☐**Female**

Birth date: ___/___/___ Age: ___ SS#: ____________

Home Address: ____________________
Apt/Condo#

____
City State Zip

2 Who is accompanying the child today?

Name: ____________________ **Relation**: ________
Last First MI

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** ☐**Divorced** ☐**Separated** ☐**Single** ☐**Widowed**

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

Name: ____________________

Employer: ____________________

Home #: ( ) ________ Ext:____ SS#: ____________

Work #: ( ) ________ Ext:____

Birth date: ___/___/___ Age: ___ DL#: ____________

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

Name: ____________________

Employer: ____________________

Home #: ( ) ________ Ext:____ SS#: ____________

Work #: ( ) ________ Ext:____

Birth date: ___/___/___ Age: ___ DL#: ____________

4 Insurance Coverage

Do your child have Dental Insurance Coverage?

Primary ☐ Yes ☐ No

Secondary ☐ Yes ☐ No

If yes, please give your insurance cards to the receptionist.

5

In the event of an emergency, who is the nearest person we should contact?

His/Her Name: ____________________ Relation: ________

Work #: ( ) ________ Ext:____ Home #: ( ) ________

6 Person Responsible for account:

Name: ____________________ Relation: ________
Last First MI

Employer: ____________ SS#: ____________

Work #: ( ) ________ Ext:____ Home #: ( ) ________

Birth date: ___/___/___ Age: ___ DL#: ____________

Billing Address: ____________________

7 Medical History

Does your child have a personal physician? ☐ Yes ☐ No

Physician's Name: ____________________

Phone #: ( ) ________ Date of last visit: ____________

CONTINUED ON THE NEXT PAGE

Initial Here: ____________

7 Medical History *continued*

Your child's current physical health is: ☐Good ☐Fair ☐Poor

Are he/she currently under the care of a physician? ☐Yes ☐No

Please Explain: ____________________

Are he/she taking any prescription/over-the-counter drugs? ☐Yes ☐No

Please list each one: ____________________

Does the child have any of the following habits:

Lip sucking/biting?	☐Yes	☐No
Nail biting?	☐Yes	☐No
Thumb/finger sucking?	☐Yes	☐No

Has he/she ever had any of the following diseases or medical problems? (Please circle Y for yes or N for no.)

Y	**N**	Abnormal Bleeding	**Y**	**N**	Heart Surgery
Y	**N**	Alcohol abuse	**Y**	**N**	Hemophilia
Y	**N**	Allergies	**Y**	**N**	Hepatitis A
Y	**N**	Anemia	**Y**	**N**	Hepatitis B
Y	**N**	Angina Pectoris	**Y**	**N**	High Blood Pressure
Y	**N**	Arthritis	**Y**	**N**	HIV+/AIDS
Y	**N**	Artificial bones or joints	**Y**	**N**	Kidney Problems
Y	**N**	Artificial Heart Valve	**Y**	**N**	Liver Disease
Y	**N**	Asthma	**Y**	**N**	Low Blood Pressure
Y	**N**	Blood Transfusion	**Y**	**N**	Mitral Valve Prolapse
Y	**N**	Cancer - Chemotherapy	**Y**	**N**	Pace Maker
Y	**N**	Colitis	**Y**	**N**	Pneumocystitis
Y	**N**	Congenital Heart Defect	**Y**	**N**	Psychiatric Problems
Y	**N**	Cosmetic Surgery	**Y**	**N**	Radiation Therapy
Y	**N**	Diabetes	**Y**	**N**	Rheumatic Fever
Y	**N**	Difficulty Breathing	**Y**	**N**	Seizures
Y	**N**	Drug Abuse	**Y**	**N**	Shingles
Y	**N**	Emphysema	**Y**	**N**	Sickle Cell Disease
Y	**N**	Epilepsy	**Y**	**N**	Sinus Problems
Y	**N**	Fainting Spells	**Y**	**N**	Stroke
Y	**N**	Fever Blisters	**Y**	**N**	Thyroid Problems
Y	**N**	Frequent Headaches	**Y**	**N**	Tuberculosis
Y	**N**	Glaucoma	**Y**	**N**	Ulcers
Y	**N**	Hay Fever	**Y**	**N**	Venereal Disease
Y	**N**	Heart Attack	**Y**	**N**	Yellow Jaundice
Y	**N**	Heart Murmur			

Please list any other serious medical condition(s) that he/she has ever had:

____

____

Does he/she have any allergies?

Y	**N**	Aspirin	**Y**	**N**	Latex
Y	**N**	Codeine	**Y**	**N**	Metals
Y	**N**	Dental Anesthetics	**Y**	**N**	Penicillin
Y	**N**	Erythromycin	**Y**	**N**	Tetracycline
Y	**N**	Jewelry	**Y**	**N**	Other (please list below)

____

____

We are committed to excellence in helping your child achieve oral health. Our goal is to recommend and provide the highest quality of treatment that modern dentistry has to offer to meet your child's needs, and to do so in a state of the art facility. We are committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

8 Dental History

Why have you brought this child to the dentist today?

____

____

Does he/she require antibiotics before dental treatment? ☐Yes ☐No

Is he/she currently in pain? ☐Yes ☐No

Has he/she ever had a serious/difficult problem associated with any previous dental work? ☐Yes ☐No

Has he/she now or has he/she ever experienced pain/discomfort in his/her jaw joint (TMJ/TMD)? ☐Yes ☐No

His/Her current dental health is: ☐Good ☐Fair ☐Poor

Does he/she like his/her smile? ☐Yes ☐No

Would he/she like whiter teeth? ☐Yes ☐No

Do his/her gums ever bleed? ☐Yes ☐No

How many times a week does he/she floss? ____________________

a day does he/she brush? ____________________

Type of bristles? ☐Soft ☐Medium ☐Hard

***** Use this area to tell us any other information about your child's medical/dental history or problems he/she may be having that are not explained elsewhere on this form.

____

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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 the 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 during diagnosis and treatment with my informed consent.

____

Signature Date