

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.

1

Tell Us About Your Child

Today's Date: _____

Child's Name:

Nickname: _____ LAST FIRST MI ☐ Male ☐ Female

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

School: _____ Grade: ____

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

E-mail Address: _____

Child's Home Address:

APT/CONDO # _____

CITY _____ STATE _____ ZIP _____

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: _____

Last Visit Date: _____

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

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Parent: ☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

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

Employer: _____ Wk #: (____)

SS #: _____ DL #: _____

Parent: ☐ Father ☐ Mother ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

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

Employer: _____ Wk #: (____)

SS #: _____ DL #: _____

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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 #: _____

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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

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

CONTINUED ON BACK

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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 received Covid-19 vaccination? ☐ Yes ☐ No
Type? _____ Date(s)? _____

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

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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

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 Covid-19
<input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHD	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes
<input type="checkbox"/> Y <input type="checkbox"/> N Allergies to any drugs	<input type="checkbox"/> Y <input type="checkbox"/> N Handicaps / Disabilities
<input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays	<input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment
<input type="checkbox"/> Y <input type="checkbox"/> N Any Operations	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia
<input type="checkbox"/> Y <input type="checkbox"/> N Asperger Syndrome	<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 Autism	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney / Liver Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits
<input type="checkbox"/> Y <input type="checkbox"/> N Convulsions / Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)

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

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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 in case of emergency.

Name: _____ Phone: (____) _____

Address: _____

CITY

STATE

ZIP

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature _____

Date _____

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: _____