

# WELCOME!

We would like to welcome 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

Child's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age: \_\_\_\_\_

Nickname: \_\_\_\_\_  Male  Female

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Child's Home #: (\_\_\_\_) \_\_\_\_\_ SS #: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_  
Apt / Condo # \_\_\_\_\_

City State Zip

## General Information

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 siblings: \_\_\_\_\_

Previous/Present Dentist: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

Dentist's Phone: (\_\_\_\_) \_\_\_\_\_

Relative or Friend not living with you:  
Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

## Parent's Information

Parent's Marital Status  Single  Married  Partnered  Widowed  Divorced  Separated

Father  Step Father  Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: (If different than Child's) \_\_\_\_\_  
\_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Cell/Other #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:  
Insurance Co. Name: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
City State Zip

Insurance Phone: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Mother  Step Mother  Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: (If different than Child's) \_\_\_\_\_  
\_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Cell/Other #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:  
Insurance Co. Name: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
City State Zip

Insurance Phone: (\_\_\_\_) \_\_\_\_\_


Group # (Plan, Local, or Policy #): \_\_\_\_\_

## Release

I certify that my child is covered by \_\_\_\_\_ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian

Date

 CONTINUED ON BACK

# Dental & Medical History

Why did you bring the child to the dentist today? \_\_\_\_\_  
 \_\_\_\_\_

Has the child ever taken any diet pills such as Phen-Fen?  Yes  No

(Also known as Redux or Pondimin.) If so, when? \_\_\_\_\_

Is the child currently in pain?  Yes  No

Does the child require antibiotics before dental treatment?  Yes  No

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

Please list all drugs that the child is currently taking:  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list all drugs/things that the child is allergic to:  
 \_\_\_\_\_  
 \_\_\_\_\_

## Has the child experienced the following medical problems?

- |   |                                |   |                       |
|---|--------------------------------|---|-----------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Abnormal Bleeding              | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Murmur          |
| <input type="checkbox"/> Y <input type="checkbox"/> N | ADD/ADHD                       | <input type="checkbox"/> Y <input type="checkbox"/> N | Hemophilia            |
| <input type="checkbox"/> Y <input type="checkbox"/> N | AIDS/HIV+                      | <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis             |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Anemia                         | <input type="checkbox"/> Y <input type="checkbox"/> N | High Blood Pressure   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Any Hospital Stays/Operations? | <input type="checkbox"/> Y <input type="checkbox"/> N | Hives                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Artificial Bones/Joints/Valves | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney Problems       |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Asthma                         | <input type="checkbox"/> Y <input type="checkbox"/> N | Liver Problems        |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Cancer                         | <input type="checkbox"/> Y <input type="checkbox"/> N | Low Blood Pressure    |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Chicken Pox                    | <input type="checkbox"/> Y <input type="checkbox"/> N | Measles               |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Congenital Heart Defect        | <input type="checkbox"/> Y <input type="checkbox"/> N | Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Convulsions                    | <input type="checkbox"/> Y <input type="checkbox"/> N | Mononucleosis         |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes                       | <input type="checkbox"/> Y <input type="checkbox"/> N | Prosthetics           |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Epilepsy                       | <input type="checkbox"/> Y <input type="checkbox"/> N | Rheumatic Fever       |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Exposed to HIV, but Neg.       | <input type="checkbox"/> Y <input type="checkbox"/> N | Scarlet Fever         |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Handicaps/Disabilities         | <input type="checkbox"/> Y <input type="checkbox"/> N | Skin Rash             |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Hearing Impairment             | <input type="checkbox"/> Y <input type="checkbox"/> N | Tuberculosis (TB)     |

Are the child's immunizations current?  Yes  No

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

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

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

- |   |                          |   |                       |
|---|--------------------------|---|-----------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Breast Fed               | <input type="checkbox"/> Y <input type="checkbox"/> N | Nursing Bottle Habits |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Chewing on Objects       | <input type="checkbox"/> Y <input type="checkbox"/> N | Speech Problems       |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Clenching/Grinding Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N | Thumb/Finger Sucking  |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Lip Sucking/Biting       | <input type="checkbox"/> Y <input type="checkbox"/> N | Tongue/Cheek Biting   |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Mouth Breather           | <input type="checkbox"/> Y <input type="checkbox"/> N | Tongue Thrust         |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Nail Biting              | <input type="checkbox"/> Y <input type="checkbox"/> N | Used Pacifier         |

**Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

I affirm that the information I have given is correct to the best of my knowledge. It 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 the necessary dental services my child may need.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

## OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

\_\_\_\_\_  
Signature of Dentist

\_\_\_\_\_  
Date

Dentist's Comments: \_\_\_\_\_  
 \_\_\_\_\_

## Medical History Update

Has there been any change in your child's health status since their last visit?  Y  N

If Yes, please explain. \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

\_\_\_\_\_  
Date

Has there been any change in your child's health status since their last visit?  Y  N

If Yes, please explain. \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

\_\_\_\_\_  
Date