# **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

#### **General Information**

		Т	oday's Date: _		
Child's Name:	Last		First	-	M
Child's Birthdate:		_/		ge:	
Nickname:			E	Male	Female
School:				_ Grade: _	
Hobbies:	1		-	_	
Child's Home #: (	)		5	SS #:	
Child's Home Address:					
					Apt / Condo #
City			State		Zip

Who is accompanying the child today?		
Name:	Relation:	
Do you have legal custody of this child? Whom may we Thank for referring you		Ves I No
Other siblings:	was deal to make the	
Previous/Present Dentist:	Last Visit	Date:
Dentist's Phone: ()		
Relative or Friend not living with you:		
Name:	Phone: (	)
Address:		
City Str	nte	Zip

## **Parent's Information**

Who is responsible for account? Parent's Marital Status	Single Married Partnered Widowed Divorced Separated
□ Father □ Step Father □ Guardian	Mother Step Mother Guardian
Name: Birthdate://	Name: Birthdate:/
Address: (If different than Child's) Hm #: ()	Address: (If different than Child's) Hm #: ()
SS #: DL #:	SS #: DL #:
Wk #: () Ext:Cell/Other #: ()	Wk #: () Ext: Cell/Other #: ()
	Email: Exit exit exit
Email:	
Employer:	Employer:
Employer's Address:	Employer's Address:
City Stole Zip	City State Zip
If you have Dental Insurance Coverage for the Child, please fill out below:	If you have Dental Insurance Coverage for the Child, please fill out below:
Insurance Co. Name:	Insurance Co. Name:
Insurance Address:	Insurance Address:
City Stote Zip	City State Zip
Insurance Phone: ()	Insurance Phone: ()
Group # (Plan, Local, or Policy #):	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	
Contraction of the local division of the loc		_		

Date

Dental & A		-			1. I. II
Why did you bring the child to the dentist today?	YN	Has the child experienced the for Abnormal Bleeding / Hemophilic			edical problems? Heart Murmur
	- YN	ADD/ADHD		N	
	- V N	AIDS/HIV+	Y	N	Hepatitis Hives/Skin Rash
as the child ever taken any diet pills such as Phen-Fen? 🛛 🗌 Yes 🗌 N	YN	Anemia	Y	N	Kidney Problems
(Also known as Redux or Pondimin.) If so, when?	- YN	Any Hospital Stays/Operations?	Y	N	Liver Problems
s the child currently in pain? 🛛 Yes 🗌 N	OYN	Artificial Bones/Joints/Valves	Y	N	Low/High Blood Press
Does the child require antibiotics before dental treatment? 🛛 🗌 Yes 🔲 N	O Y N	Asthma	Y	N	Lupus
tas the child ever had a serious/difficult problem associated with	YN	Cancer	Y	Ν	Measles
previous dental work? 🛛 Yes 🗌 N		Chicken Pox	Y	Ν	Mitral Valve Prolapse
s the child's water fluoridated? 🛛 Yes 🗌 N	OYN	Congenital Heart Defect	Y	N	Mononucleosis
s the child taking fluoridated supplements? 🛛 🖄 Yes 🗔 N	O Y N	Convulsions	Y	N	Prosthetics
tas the child ever had any pain/tenderness in his/her	YN	Diabetes	Y	N	Rheumatic Fever
aw joint (TMJ/TMD)?		Epilepsy	Y	N	Scarlet Fever Sickle Cell Disease
Does the child brush his/her teeth daily? 🛛 Yes 🗌 N	V N		Y	NN	Sickle Cell Disease Stroke
Floss his/her teeth daily? 🗌 Yes 🗌 N	O Y N	Hanaicaps/Disabilities Hearing Impairment	Y	N	Tuberculosis (TB)
Child's Physician:	1 1 1			IN	
Phone #: Date of Last Visit:		e child's immunizations current?	hen		Yes 🗌
s the child currently under the care of a physician?		ng you would like to discuss with th			
	Please	discuss any serious medical proble	ms th	e chil	d experiences/ed:
'lease describe the child's current physical health:					
lease list all prescription / over the counter or supplement drugs that the		and the second second			
	Does/	did the child experience any of the	follow	ving?	
nild is currently taking:	YN		Y	N	Nursing Bottle Habits
	- YN	Chewing on Objects	Y	N	Speech Problems
			11	NI	Thumb/Finger Suckir
	- YN	Clenching/Grinding Teeth	Y	N	indino, inigoi oocini
Aside from the items listed, please list all drugs/things that the child is allergic to:	1 200	Lip Sucking/Biting	Y	N	
side from the items listed, please list all drugs/things that the child is allergic to:	Y N Y N Y N	Lip Sucking/Biting Mouth Breather			Tongue/Cheek Biting Tongue Thrust
Aside from the items listed, please list all drugs/things that the child is allergic to: Y N Latex Y N Metals/Nickel Y N Plastic Our office is HIPAA Compliant and is committed to meeting or exceeding	Y N Y N Y N Y N	Lip Sucking/Biting Mouth Breather Nail Biting	Y Y Y	N N N	Tongue/Cheek Biting Tongue Thrust Used Pacifier
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