Patient ID# _____

Today's Date _____

Welcome

to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Your Child

Child's Name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

SS#/SIN _____

School _____ Grade _____

Child's Home Address _____

_____

City _____

State/Prov. ___ Zip/P.C. _____

Phone _____

_____

Responsible Party

Name _____

Relationship _____

Address _____

_____

SS#/SIN _____

DL # _____

Email _____

☐ Mother

☐ Stepmother ☐ Guardian

Name _____

Home Phone _____

Work Phone _____

Cell Phone _____

SS#/SIN _____

Employer _____

_____

Occupation _____

_____

DL # _____

_____

☐ Father

☐ Stepfather ☐ Guardian

Name _____

Home Phone _____

Work Phone _____

Cell Phone _____

SS#/SIN _____

Employer _____

_____

Occupation _____

_____

DL # _____

_____

Primary Dental Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Emp. _____

Occupation _____

Ins. Company _____ Group # _____ Emp. # _____

Ins. Company Address _____

Deductible _____ Amount already used _____ Max. annual benefit _____

Orthodontic coverage ☐ Yes ☐ No

Additional Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS#/SIN _____ Employer _____

Date Emp. _____ Occupation _____

Ins. Company _____ Group # _____ Emp. # _____

Ins. Company Address _____

Deductible _____ Amount already used _____

Max. annual benefit _____

Orthodontic coverage ☐ Yes ☐ No

Parent's Marital Status

☐ Single ☐ Divorced

☐ Married ☐ Widowed

☐ Separated

Who is responsible for making appointments?

Name _____

Home Phone _____

Work Phone _____ Ext. _____

Cell Phone _____

Best time to call (Time) _____ (Days) _____

Health History

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has your child had difficulty with previous visits? _____

Does your child have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? _____

Has your child ever taken Fen-Phen/Redux? _____

Has your child ever had any of the following:

Asthma ☐ YES ☐ NO
Cancer ☐ YES ☐ NO
Hepatitis ☐ YES ☐ NO
HIV/AIDS ☐ YES ☐ NO
Hemophilia ☐ YES ☐ NO
Diabetes ☐ YES ☐ NO
Allergies ☐ YES ☐ NO
Rheumatic Fever ☐ YES ☐ NO
Congenital Heart Defect ☐ YES ☐ NO
Handicaps/Disabilities ☐ YES ☐ NO
Convulsions/Epilepsy ☐ YES ☐ NO
Tuberculosis ☐ YES ☐ NO
Abnormal Bleeding ☐ YES ☐ NO
Heart Murmur ☐ YES ☐ NO

Please explain any medical problems that your child has

_____
_____
_____
_____
_____
_____

Child's Habits

How often does your child brush? _____

How often does your child floss? _____

Date of last dental visit _____

Previous Dentist _____

Child's Physician _____

Phone Number _____

Child's Birthdate _____

Is your child's water fluoridated? ..... ☐ YES ☐ NO

Does your child take fluoride supplements? ☐ YES ☐ NO

Does your child:

Suck thumb/finger ..... ☐ YES ☐ NO

Suck/Bite lips ..... ☐ YES ☐ NO

Bite/Chew nails ..... ☐ YES ☐ NO

Chew hard objects (Pencils, etc.) ..... ☐ YES ☐ NO

Grind Teeth ☐ YES ☐ NO

Clench jaws ..... ☐ YES ☐ NO

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient or parent/guardian if minor

_____
Date

Dentist's Review

_____
_____
_____
_____

Date _____

Signed Dr. _____

Health History Update

Date _____

Comments _____
_____

Signature _____

Date _____ Comments _____

_____

Signature _____