Why did you bring your 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 the jaw? (TMJ)? ❑ Yes ❑ No

Does the child brush his / her teeth daily? ❑ Yes ❑ No

Does the child 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

Please list all drugs the child is currently taking:

_____

_____

_____

Please list all drugs / materials the child is allergic to:

_____

_____

_____

Latex? ❑ Yes ❑ No **Metals?** ❑ Yes ❑ No **Plastic?** ❑ Yes ❑ No

Has the child ever had any of the following medical problems?

Y	N	Abnormal Breathing
Y	N	ADD / ADHD
Y	N	Allergies to any Drugs
Y	N	Any Hospital Stays
Y	N	Any Operations
Y	N	Artificial Bones / Joints / Valves
Y	N	Asthma
Y	N	Cancer
Y	N	Congenital Heart Defect
Y	N	Convulsions
Y	N	Diabetes
Y	N	Handicaps / Disabilities
Y	N	Hearing Impairment
Y	N	Heart Murmur
Y	N	Hemophilia
Y	N	Hepatitis
Y	N	HIV + / AIDS
Y	N	Kidney / Liver Problems
Y	N	Rheumatic / Scarlet Fever
Y	N	Sickle Cell Disease / Traits
Y	N	Tuberculosis (TB)

Does the child have any of the following habits?

Y	N	Lip Sucking / Biting
Y	N	Nail Biting
Y	N	Nursing Bottle Habits
Y	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:

Name: _____

Phone: _____

Address: _____

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 status. I authorize the dental staff to preform the necessary dental services my child may need. **The parent or guardian who accompanies this child is responsible for payment at the time of service unless prior arrangements have been approved.**

_____

Signature Date

FOR OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

Dr. Millie Cortés

The Kids Corner

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 preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Date: _____

TELL US ABOUT YOUR CHILD

Name: _____
Last First MI

Nickname: _____ ❑ Male ❑ Female

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

School: _____

Child's Home Phone: ( ) _____

Social Security #: _____

Email: _____

Child's Home Address:

_____

_____
City State Zip

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: _____

MOTHER'S INFORMATION ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: ____ / ____ / ____

Home #: ( ) _____ Cell #: ( ) _____

Employer: _____ Phone: ( ) _____

SS#: _____ DL#: _____

FATHER'S INFORMATION ❑ Step Father ❑ Guardian

Name: _____ Birthdate: ____ / ____ / ____

Home Phone: ( ) _____

Cell Phone: ( ) _____

Employer: _____ Phone: ( ) _____

SS#: _____ DL#: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____

_____

Home #: ( ) _____ Cell #: ( ) _____

Employer: _____

Wk #: ( ) _____ Ext: _____

SS#: _____

Who is responsible for making appointments?

Name: _____

Phone: ( ) _____

PRIMARY DENTAL INSURANCE

Plan Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance / Plan Phone #: _____

Employer: _____

Group #: _____ Plan#: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage: ❑ Yes ❑ No

SECONDARY DENTAL INSURANCE

Plan Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance / Plan Phone #: _____

Employer: _____

Group #: _____ Plan#: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage: ❑ Yes ❑ No