WELCOME

1 About Your Child

Today's Date: ____/____/____ File #: __________

Child's Name: ______________________________
LAST FIRST M.I.

Child's Nickname: ________________ ❑ Boy ❑ Girl

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

School: ______________________ Grade: ______

Child's Home Phone #:(______) ______________

Child's SS#: ______________________________

Child's Address: ______________________________
HOME ADDRESS

____
CITY STATE ZIP

Referred By: ______________________________
(If doctor, please give address & phone number.)

____

2 Insurance Information

Primary Dental Insurance

Co. Name: ______________________________

Address: ______________________________

____
CITY STATE ZIP

Phone #: ______________________________

Insured's ID#: ______________________________

Group # (Plan, Local, or Policy #): ______________________

Insured's Name: ______________________________

Relation: ____________ Date of Birth: ___/___/___

Insured's Employer: ______________________________

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: ______________________________

Address: ______________________________

____
CITY STATE ZIP

Phone #: ______________________________

Insured's ID#: ______________________________

Group # (Plan, Local, or Policy #): ______________________

Insured's Name: ______________________________

Relation: ____________ Date of Birth: ___/___/___

Insured's Employer: ______________________________

3 Child's Family Information

Who is accompanying this child today?

______________________________ ______________________
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters? ______ Age(s): _____ _____ _____

______________________________ ______________________
MOTHER'S NAME ❑ STEP MOTHER ❑ GUARDIAN EMAIL ADDRESS

____
(❑ CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(______)__________ (______)__________ ______
HOME PHONE # WORK PHONE # EXT.

______________ ____/____/____ ______________
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: ______________________ How Long?______

____
EMPLOYER'S ADDRESS CITY STATE ZIP

______________________________ ______________________
FATHER'S NAME ❑ STEP FATHER ❑ GUARDIAN EMAIL ADDRESS

____
(❑ CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(______)__________ (______)__________ ______
HOME PHONE # WORK PHONE # EXT.

______________ ____/____/____ ______________
FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: ______________________ How Long?______

____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account

Name: ______________________ ______________________
RELATION TO CHILD

Billing Address: ______________________________

____
CITY STATE ZIP

______________ ____/____/____
SOCIAL SECURITY # DATE OF BIRTH

(______)__________ ______ (______)__________
WORK PHONE #: EXT. CELL PHONE #:

________ I hereby authorize assignment of my insurance rights and
Initials benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please Continue On Back

5 Child's Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Child in pain? ❑ No ❑ Yes How Long?___________

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth ❑ Loose tooth
❑ Other(s): ___________

Does child require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: ___________ (____) ___________

Last Dental exam: ____ / ____ / ____ Last Dental X-rays: ____ / ____ / ____

Times a day child brushes? _______ Times a week child flosses? ___________

Is the child's water fluoridated? ❑ Yes ❑ No

How would you rate the child's smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

6 Child's Medical History

Is Child taking any of the following medications? ❑ Pain killers (INCLUDING ASPIRIN) ❑ Ritalin ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle relaxers ❑ Others: ___________

Child's Physician: ___________ (____) ___________
DOCTOR'S NAME OR CLINIC NAME PHONE#

___________ Last Medical Exam: ____ / ____ / ____
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur
Y N Rheumatic fever
Y N Artificial Heart Valves
Y N Congenital Heart defect
Y N Scarlet Fever
Y N Surgeries/Operations
Y N Cancer/Tumors
Y N Chemotherapy
Y N Jaw Problems TMJ/TMD
Y N Hearing Problems
Y N Tonsillitis
Y N Respiratory Problems
Y N Asthma/Difficulty Breathing
Y N Blood Transfusion(s)
Y N Leukemia/Anemia
Y N Diabetes/Hypoglycemia
Y N Hemophilia
Y N Abnormal Bleeding
Y N Cleft Lip/Palate
Y N Birth Defects
Y N High/Low Blood Pressure
Y N Hepatitis
Y N Artificial Bones/Joints/Implants
Y N Liver/Kidney/Organ Problems
Y N HIV+/AIDS/ARC
Y N Tuberculosis TB
Y N Psychiatric Problems
Y N Hyper Active/ADD
Y N Fainting/Seizures/Epilepsy
Y N Cerebral Palsy

Please list any other medical condition(s) child has or ever had: ___________

Is Child allergic to: ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics (Novocaine)
❑ Aspirin ❑ Food allergies ❑ Other(s): ___________

Please rate the child's general health from 1-10: _______ Does child wear contact lenses? ❑Yes ❑No

Has this child ever taken the drug Ritalin? ❑ No ❑ Yes/How long? _______ Child's Blood type: ______

Does this child do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking
❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_______ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**
Initials

Signature ___________ Date ____ / ____ / ____
❑ Parent or Guardian ❑ Other:

UPDATE
(OFFICE USE)

_____ Initials ___/___/___ Date
Comments

_____ Initials ___/___/___ Date
Comments

_____ Initials ___/___/___ Date
Comments

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DiMariano
LET OUR FAMILY TREAT YOURS
FAMILY DENTISTRY & ORTHODONTICS

Dental Assessment Form (Ages 0-6)

Today's Date: ____________

Patient's Name:	Date of Birth:		Age:
Fluoride Exposure: (Circle One)			
Child uses Fluoride toothpaste	Yes	No	Occasionally
Child has had professional Fluoride application	Yes	No	
Child takes Fluoride supplements	Yes	No	Occasionally
Sugary Foods & Drinks: (Circle One)			
Child drinks fruit juice	Daily	Weekly	Rarely
Child drinks soft drinks (carbonated and/or non-carbonated)	Daily	Weekly	Rarely
Child eats sticky and/or sugary foods (fruit snacks, granola bars, dried fruit, raisins, etc)	Daily	Weekly	Rarely
Child takes medicinal syrups	Frequently	Occasionally	Rarely
Caries (Cavity) History: (Circle One)			
Child has history of cavities	Yes	No	Unsure
Parents, Caregiver and/or Siblings history	No cavities in last 24 months	Cavities in last 7-23 months	Cavities in last 6 months
Dental Home: (Circle One)			
Does child have established dental records at another dental office?	Yes	No	
Oral Habits: (Circle One)			
How often does child brush their teeth?	Once Daily	Twice Daily	Other
If *other*, please specify:			
Is brushing assisted by Parent or Caregiver?	Yes	No	
Child has history of the following: (Please check current or past habit below)	Pacifier and/or Thumb Sucking ☐ Past Habit ☐ Current Habit	Biting Nails ☐ Past Habit ☐ Current Habit	Chewing On Things ☐ Past Habit ☐ Current Habit