



Welcome!

Proper dental hygiene begins at an early age. Please take a few minutes to complete the following information so we can better care for your child's dental needs.

Child's Name Birthdate Male Female
 Social Security # Home Phone
 Home Address Cell Phone
 City State Zip
 School Grade
 Responsible Party
 Relationship to Child
 Name of Mother/Guardian Birthdate
 Social Security # Home Phone
 Address
 City State Zip
 Employer Business Phone
 Cell Phone E-mail
 Name of Father/Guardian Birthdate
 Social Security # Home Phone
 Address
 City State Zip
 Employer Business Phone
 Cell Phone E-mail

Child's Dental History

Date of Last Dental Visit / /
 Name of Former Dentist
 Telephone Number - - -

ALLERGIES

Penicillin
 Aspirin
 Sulfa
 Other

How often does your child brush?
 How often does your child floss?
 Please check all that apply to your child:
 Thumb/Finger Sucking Fingernail Biting Grinding Teeth
 Lip or Cheek Biting Jaw Difficulty Clicking and/or Pain

Child's Health History

Please check all that apply to your child:
 Hepatitis Diabetes
 Anemia Epilepsy
 Asthma HIV/AIDS
 Cancer Heart Murmur
 Other

Insurance
 Signature of Responsible Party
 Date ----- / ----- / -----

Form #4073

