

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.

Patient ID# _____

Today's Date _____

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 _____
Phone _____

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) _____

Over Please

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 history of allergies to any substances (latex, environmental, etc.)? _____

Has your child ever had any of the following:

- | | |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Acid Reflux <input type="checkbox"/> YES <input type="checkbox"/> NO | Hearing Impairment <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Allergies <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Problems <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Anemia <input type="checkbox"/> YES <input type="checkbox"/> NO | Hemophilia/Abnormal Bleeding <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO | Hepatitis <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Blood Transfusion <input type="checkbox"/> YES <input type="checkbox"/> NO | HIV/AIDS <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO | Persistent Cough <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Convulsions/Epilepsy <input type="checkbox"/> YES <input type="checkbox"/> NO | Rheumatic Fever <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Handicaps/Disabilities <input type="checkbox"/> YES <input type="checkbox"/> 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 _____