Welcome!

Tell Us About Your Child

Today's Date: ______________ Child's Home Phone #: (_____)______________ Social Security #: ______________

Child's Name: ______________________________ (Last / First / MI) Child's Birthdate: ___/___/___ Child's Age: ______

Nickname: ______________ ❑ Male ❑ Female School: ______________ Grade: ______

Child's Home Address: ______________________________ (Street / City / State / Zip)

Whom may we thank for referring you? ______________________________

Email Address: ______________________________

Parent's Information

Parent's Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Remarried ❑ Single ❑ Partnered

Mother Birthdate: ___/___/___ Home Phone #: (_____)______________ Work Phone #: (_____)______________

Name: ______________ Social Security #: ______________ Driver's License #: ______________

Address: ______________________________ (Street / City / State / Zip)

Employer: ______________ Length of Employment: ______________

Father Birthdate: ___/___/___ Home Phone #: (_____)______________ Work Phone #: (_____)______________

Name: ______________ Social Security #: ______________ Driver's License #: ______________

Address: ______________________________ (Street / City / State / Zip)

Employer: ______________ Length of Employment: ______________

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: ______________ Phone #: (_____)______________ Group # (Plan, Local, or Policy #): ______________

Insurance Co. Address: ______________________________ (PO Box/Street / City / State / Zip)

Insured's Name: ______________ Relationship to Patient: ______________

Insured's Birthdate: ___/___/___ Insured's ID #: ______________ Insured's Employer: ______________

Employer's Address: ______________________________ (Street / City / State / Zip)

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: ______________ Phone #: (_____)______________ Group # (Plan, Local, or Policy #): ______________

Insurance Co. Address: ______________________________ (PO Box/Street / City / State / Zip)

Insured's Name: ______________ Relationship to Patient ______________

Insured's Birthdate: ___/___/___ Insured's ID #: ______________ Insured's Employer: ______________

Employer's Address: ______________________________ (Street / City / State / Zip)

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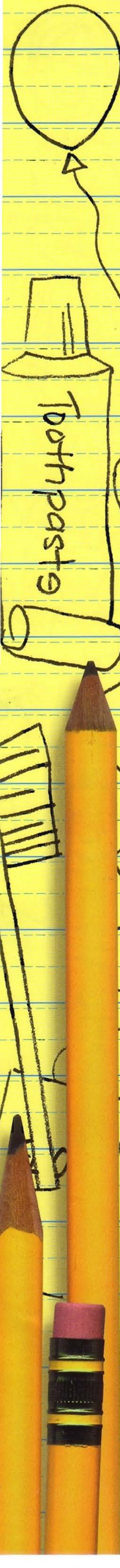

Dental History

Is the child currently in pain? ❑ **Yes** ❑ **No** **What is the primary reason for today's visit?** ____________

Has the child experienced problems with previous dental work? ❑ Yes ❑ No

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

Floss his / her teeth daily? ❑ Yes ❑ No

Previous / Present Dentist: ____________ Date of Last Visit ____________
(Please Circle)

Why did you leave your previous dentist? ____________

What did you like most about any dentist you have seen? ____________ Least? ____________

Does / did the child have any of the following habits?

Y N Lip Sucking / Biting	Y N Clenching / Grinding Teeth	Y N Tongue / Cheek Biting	Y N Mouth Breather
Y N Nail Biting	Y N Thumb / Finger Sucking	Y N Used Pacifier	Y N Speech Problems
Y N Chewing on Objects	Y N Nursing Bottle Habits	Y N Tongue Thrust	Y N Breast Fed

Medical History

Child's Physician: ____________ Phone #: (____)________ Date of last visit: ____________

Address: ____________
Street City State Zip

Is the child currently under the care of a physician? ❑ Yes ❑ No Please explain: ____________

Please describe the child's current physical health: ❑ Good ❑ Fair ❑ Poor **Are Immunizations Current?** ❑ Yes ❑ No

Please list all drugs that the child is currently taking: ____________

Besides the following, please list all drugs and/or things that cause the child allergic reactions:

Latex? ❑ Yes ❑ No Metals/Nickel ❑ Yes ❑ No Plastic? ❑ Yes ❑ No Penicillin? ❑ Yes ❑ No Tetracycline? ❑ Yes ❑ No

____

____

Anything you would like to discuss with the Doctor in private? ❑ Yes ❑ No

Has the child had/experienced any of the following:

Y N Abnormal Bleeding	Y N Congenital Heart Defect	Y N High Blood Pressure	Y N Rheumatic Fever
Y N AIDS / HIV+	Y N Convulsions	Y N Hives	Y N Scarlet Fever
Y N Allergies	Y N Diabetes	Y N Kidney Problems	Y N Sickle Cell Anemia
Y N Anemia	Y N Epilepsy	Y N Liver Problems	Y N Skin Rash
Y N Any Hospital Stay/Operations	Y N Handicaps / Disabilities	Y N Low Blood Pressure	Y N Tonsillitis
Y N Asthma	Y N Hearing Impairment	Y N Lupus	Y N Tuberculosis (TB)
Y N Blood Transfusion	Y N Heart Murmur	Y N Measles	
Y N Cancer	Y N Hemophilia	Y N Mitral Valve Prolapse	
Y N Chicken Pox	Y N Hepatitis	Y N Mononucleosis	

Please discuss any serious medical problems the child experiences/ed: ____________

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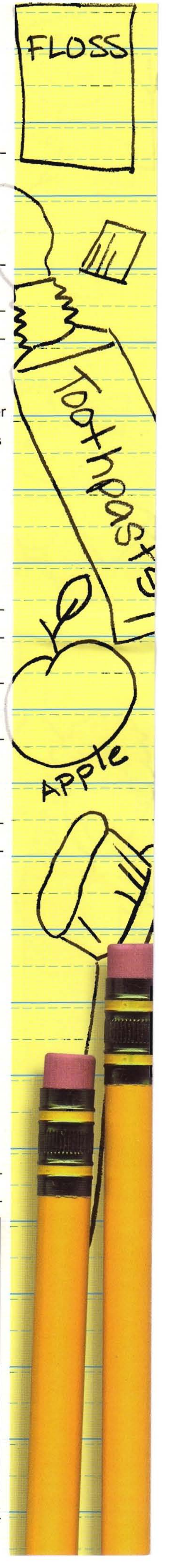
Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

____________ ____________
Signature Date



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