FOR CHILDREN: WELCOME TO OUR PRACTICE

1. TELL US ABOUT YOUR CHILD

Today's date: ______ DOB: ______

Child's Name: Age: ______

______

Last First Middle

Nickname: ______ ☐ Male ☐ Female

School: ______ Grade: ______

Home#: ______ SS#: ______

Child's Home Address:

______

Apt#:

______

City State Zip

Siblings:

Name: ______ Age: ______

Name: ______ Age: ______

2. WHO IS WITH THE CHILD TODAY?

Name: ______

Relation: ______

Do you have legal custody of this child? ☐ Yes ☐ No

Who may we thank for referring you? ______

Other family members seen by us: ______

Previous/Present Dentist: ______

Street: ______

Phone #: ______ Last Visit: ______

Parent's Marital Status: ______

(Single, Married, Divorced)

3. MOTHER'S INFORMATION

Name: ______ Cell#: ______

WK#: ______ Ext. ______ Home#: ______

Employer: ______

DL#: ______ SS#: ______

FATHER'S INFORMATION

Name: ______ Cell#: ______

WK#: ______ Ext. ______ Home#: ______

Employer: ______

DL#: ______ SS#: ______

4. RESPONSIBLE PARTY INFO

Name: ______

Billing address : ______

______

City State Zip

WK#: ______ Ext. ______ Home#: ______

Cell#: ______

Email: ______

Employer: ______

SS#: ______

5. PRIMARY DENTAL INSURANCE

Ins. Name: ______

Ins. address : ______

______

Insurance Co. Phone #: ______

Group/Policy # : ______

______

Insured's Name: ______

Relationship to Patient: ______

Insured's DOB: ______

Insured's Employer: ______

SS#: ______

Orthodontic Coverage ☐ Yes ☐ No

SECONDARY DENTAL INSURANCE

Ins. Name: ______

Ins. address : ______

______

Insurance Co. Phone #: ______

Group/Policy # : ______

______

Insured's Name: ______

Relationship to Patient: ______

Insured's DOB: ______

Insured's Employer: ______

SS#: ______

Orthodontic Coverage ☐ Yes ☐ No

6. Why did you bring the child to the dentist today?
dentist today?

Has the child ever had a serious/difficult problem associated with 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 or tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush teeth daily? ☐ Yes ☐ No

Floss their teeth daily? ☐ Yes ☐ No

Is the child currently under the care of a physician? ☐ Yes ☐ No

Child's Physician: ______________________

Phone #: ______________ Last Visit: __________

Explain: ______________________

Please describe the child's health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs the child is currently taking: ______________

Please list all drugs the child is allergic to: ______________

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

Yes	No		Yes	No	
☐	☐	Heart Murmur	☐	☐	Congenital Heart Def.
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Hearing Impairment
☐	☐	HIV+/AIDS	☐	☐	Any Operations
☐	☐	Hemophilia	☐	☐	Any Stays in Hospital
☐	☐	Asthma	☐	☐	Kidney/Liver Problems
☐	☐	Hepatitis	☐	☐	Handicaps/Disabilities
☐	☐	Tuberculosis	☐	☐	Allergies to Any Drugs
☐	☐	Prosthesis	☐	☐	History of Scarlet Fever

Please discuss any serious medical problems that the child has had:

8. Does the child have any of the following habits?

Yes	No		Yes	No	
☐	☐	Thumb sucking / Finger sucking	☐	☐	Nail Biting
☐	☐	Lip sucking / biting	☐	☐	Nursing Bottle Habits

Our office Is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

9. I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child 's medical status.

Signature of parent/guardian_____________________________ Date:_____________________

The parent/guardian who accompanies the child is responsible for payment at time of service service unless prior arrangements have been approved.

OFFICE USE ONLY --- OFFICE USE ONLY --- OFFICE USE ONLY

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

Initials: __________________ Date:__________________

Doctor 's comments:________________________________

____

Medical History Update:

1. Date:____________ Signature:______________

Comments:________________________________

1. Date:____________ Signature:______________

Comments:________________________________