WELCOME

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

PLEASE BRING WITH YOU A COMPLETE LIST OF ANY MEDICATIONS YOUR CHILD IS TAKING (PRESCRIPTION & OVER-THE-COUNTER).

1. Tell Us About Your Child

Today's Date_____

Child's Full Name_____

Nickname_____ ❑ M ❑ F

Birth date ____/____/____ Age_____ SS#_____-____-_____

Home Address: _____

_____

E-mail to confirm appointments: _____

Hm # _____ Grade_____

School _____

2. Who Is Accompanying Your Child

Name_____**Relation**_____

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

Whom may we Thank for referring you?_____

Other family members seen by us_____

_____

Previous Dentist_____

Last visit date_____Last x-ray date_____

Parent's marital status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

3. Parent's Information

❑ **Mother** ❑ **Stepmother** ❑ **Guardian**

Name_____ Birthdate____/____/____

Home#_____Work#_____Cell#_____

Employer_____**E-mail**_____

SS #_____ DL #_____

❑ **Father** ❑ **Stepfather** ❑ **Guardian**

Name _____Birthdate ____/____/____

Home#_____Work#_____Cell#_____

Employer_____**E-mail**_____

SS #_____DL #_____

4. Person Responsible for Account

Name_____ Relation_____

Billing Address_____

_____

Home#_____Work#_____Cell#_____

Employer_____E-mail_____

SS#_____ DL#_____

Who is responsible for making appointments?

Name_____

Hm # _____ Wk #_____ Cell#_____

5. Dental Insurance Information

PRIMARY DENTAL INSURANCE

Policy Owner's Employer_____

Insurance Co Name_____

Insurance Co. Address_____

_____

Insurance Co Phone #_____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name_____

Relation to Patient_____

Policy Owner's Birth date ____/____/____ SS#_____

SECONDARY DENTAL INSURANCE

WE NO LONGER FILE SECONDARY INSURANCE.

6. Your Child's Medical History

Current physical health is ❑ Good ❑ Fair ❑ Poor

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

If yes, please explain_____

Please list all prescription / over-the-counter medications that your child is currently taking_____

Please circle any medical conditions that your child has or has had:

Abnormal Bleeding
Anemia
Asthma
Blood Transfusion
Cancer/Chemotherapy
Chicken Pox
Congenital Heart Defect
Diabetes
Difficulty Breathing
Epilepsy
Fainting Spells
Frequent Headaches
Hay Fever
Hearing Impaired
Heart Murmur
Heart Surgery
Hemophilia
Hepatitis
Herpes/Fever Blisters
HIV+ / AIDS
Hospital Stay
Joint Replacement
Kidney Problems
Learning Disabilities
Liver Disease
Mitral Valve Prolapse
Operations
Psychiatric Problems
Radiation Treatment
Rheumatic Fever
Seizures
Shingles
Sickle Cell Disease
Sinus Problems
Tuberculosis (TB)

_____

Please list any OTHER medical conditions that your child has ever had_____

_____

Please Circle if your child is allergic to any of the following:

Aspirin
Codeine
Dental Anesthetic
Erythromycin
LATEX
Penicillin
Tetracycline
Other

Please list any OTHER medications/food that your child is allergic to

_____

_____

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

Child's Physician _____

Phone #_____Last Visit Date_____

7. Your Child's Dental History

Why did you bring your child to the dentist today?

_____

_____

Does your child need to be premedicated with antibiotics before dental treatment? ❑ Yes ❑ No
Is your child currently in pain? ❑ Yes ❑ No
Has your child ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No
Has your child ever experienced pain / discomfort / in his / her jaw joint (TMJ / TMD) ? ❑ Yes ❑ No

Current dental health is ❑ Good ❑ Fair ❑ Poor

Floss daily? ❑ Yes ❑ No **Brush Daily?** ❑ Yes ❑ No

Type of Bristles on child's toothbrush? ❑ Hard ❑ Medium ❑ Soft

How long does your child use his / her toothbrush before replacing it ?_____

Does your child use anything in addition to brush and floss?

If yes, what ?_____

Do your child's gums ever bleed? ❑ Yes ❑ No
Are his / her teeth sensitive to heat or cold? ❑ Yes ❑ No
Are his / her teeth sensitive to sweets? ❑ Yes ❑ No
Are his / her teeth sensitive to chewing ? ❑ Yes ❑ No

Has your child lost any teeth accidentally? ❑ Yes ❑ No

If yes, how ?_____

Has your child had orthodontic treatment? ❑ Yes ❑ No

If yes, when ?_____

Is your child's water Fluoridated? ❑ Yes ❑ No

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

Y N Lip Sucking / Biting
Y N Nail Biting
Y N Tongue / Cheek Biter
Y N Clenching / Grinding Teeth
Y N Used Pacifier
Y N Nursing Bottle Habit
Y N Thumb Sucking
Y N Mouth Breather
Y N Speech Problems
Y N Breast Fed

I understand

the information that I have given today is correct to the best of my knowledge. I also understand that this information 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. I authorize the dental staff to perform the necessary dental services that my child may need.

_____

Signature **Date**