WELCOME!

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TELL US ABOUT YOUR CHILD

Today's Date: _____

Child's Name: _____ Child's Birthdate: _____/_____/_____ Child's Age: _____
Last First MI

Child's Home Phone # : (_____)_____ Nickname: _____ M / F

Child's Home Address: _____
Street City State Zip

Name of Person Responsible for this account _____ Relationship to Patient: _____

Whom may we thank for referring you? _____

PARENT'S INFORMATION

Parent's Marital Status: _____ Married _____ Divorced _____ Separated _____ Remarried _____ Single

Mother: Birthdate: _____/_____/_____ Home Phone: (_____)_____ Work / Cell: (_____)_____

Name: _____ Drivers License # : _____

Address: _____
Street City State Zip

Email Address: _____

Employer: _____ Length of Employment: _____

Father: Birthdate: _____/_____/_____ Home Phone: (_____)_____ Work / Cell: (_____)_____

Name: _____ Drivers License # : _____

Address: _____
Street City State Zip

Email Address: _____

Employer: _____ Length of Employment: _____

INSURANCE INFORMATION

Primary Insurance:
Insurance Co. Name: _____ Phone # : (_____)_____ Group/Policy # : _____

Insurance Co. Address: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's Birthday: _____/_____/_____ Insured's Employer: _____

Secondary Insurance:
Insurance Co. Name: _____ Phone # : (_____)_____ Group/Policy # : _____

Insurance Co. Address: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's Birthday: _____/_____/_____ Insured's Employer: _____

CONTINUED ON BACK!

DENTAL HISTORY

Is your child currently in pain? Y / N What is the primary reason for today's visit? _____

Does your child brush their teeth daily? Y / N Previous / Present Dentist: _____

Do you assist with brushing? Y / N

Does your child floss their teeth daily? Y / N Date of Last Dental Visit: _____

Has your child experienced problems with previous dental work? Y / N

What is your child's attitude toward dentistry? _____

Does or has your child had any of the following habits?

____ Lip Sucking/Biting
____ Nail Biting
____Chewing on Objects
____ Clenching/Grinding Teeth
____ Thumb/Finger Sucking
____ Nursing/Bottle Habits
____ Tongue/Cheek Biting
____ Used Pacifier
____ Tongue Thrust
____ Mouth Breathing
____ Speech Problem

MEDICAL HISTORY

Child's Physician: _____ Phone # : (_____)_____ Last Visit: _____

Address : _____

Is your child currently under care of a physician? Y / N Please Explain: _____

Please describe your child's current physical health : _____ Good _____ Fair _____ Poor Are Immunizations Current? Y / N

Please list all drugs that your child is currently taking : _____

Is your child allergic to any of the following?

____ Aspirin
____ Barbiturates
____ Codeine
____ Dental Anesthetics
____ Erythromycin
____ Latex
____ Penicillin
____ Sedatives
____ Sulfa Drugs
____ Tetracycline
____ Other: _____

Has your child experienced any of the following:

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

Please discuss any serious medical problems your child experiences/ed : _____

_____

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 insurnace benefits. I understand that I am responsible for payment of services rendered, deductible, and co-payment that my insurance does not cover.

Parent / Guardian Signiture: _____ Date: _____