

Welcome

We want to help your child have the brightest smile possible. Please fill out this form completely so we can know how to best help your child reach maximum oral health. The better we know you and your child, the better we can care for you both.



your child

NAME	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	STREET ADDRESS			
NICKNAME	AGE	SS#	CITY	STATE	ZIP	
BIRTHDATE			HOME PHONE			MOBILE
SCHOOL		GRADE	PREVIOUS DENTIST			
OTHER FAMILY MEMBERS SEEN BY US			PHONE #			LAST VISIT THERE
WHO IS ACCOMPANYING THE CHILD?		RELATION	DO YOU HAVE LEGAL CUSTODY OF THIS CHILD?			<input type="checkbox"/> YES <input type="checkbox"/> NO



guardians

MOTHER NAME	BIRTHDATE	FATHER NAME	BIRTHDATE
EMPLOYER		EMPLOYER	
WORK PHONE	CELL	OTHER PERSON RESPONSIBLE FOR ACCOUNT	
SS#	DL#	RELATIONSHIP	
WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?			
BEST NUMBER TO CALL?		ADDRESS	
BEST TIMES TO CALL?		PHONE	SS#
WHO MAY WE THANK FOR REFERRING YOU?			



insurance

PRIMARY INSURANCE	DENTAL COVERAGE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	SECONDARY INSURANCE	DENTAL COVERAGE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
INSURANCE CO. NAME				INSURANCE CO. NAME			
ADDRESS				ADDRESS			
PHONE	GROUP #	PHONE	GROUP #				
INSURED NAME	RELATION	INSURED NAME	RELATION				
INSURED BIRTHDATE	IINSURED SS#	INSURED BIRTHDATE	IINSURED SS#				



medical contacts

DOES THE CHILD HAVE A PERSONAL PHYSICIAN?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	NEIGHBOR/RELATIVE TO CONTACT IN EMERGENCY:		
PHYSICIAN NAME		RELATIONSHIP			
PHONE	DATE OF LAST VISIT	HOME PHONE	MOBILE		
IS THE CHILD UNDER CARE OF THIS DOCTOR NOW?					
EXPLAIN?					
STREET ADDRESS					
CITY	STATE	ZIP			



medical history

MY CHILD'S CURRENT HEALTH IS GOOD FAIR POOR

HAS YOUR CHILD SMOKED OR USED TOBACCO IN ANY OTHER FORM? YES NO

HAS YOUR CHILD EVER HAD ANY METAL RODS, PINS OR IMPLANTS? YES NO

IS YOUR CHILD TAKING ANY PRESCRIPTION / OVER-THE-COUNTER OR HERBAL SUPPLEMENT DRUGS?

YES NO IF YES, PLEASE LIST BELOW

DOES/DID YOUR CHILD HAVE ANY OF THESE HABITS?

LIP SUCKING/BITING NAIL BITING
 THUMB-SUCKING NURSING BOTTLE HABITS

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING?

ASPIRIN CODEINE
 DENTAL ANESTHETICS ERYTHROMYCIN
 JEWELRY/METALS LATEX
 PENICILLIN TETRACYCLIN
 OTHER (PLEASE LIST)



dental history

WHY HAVE YOU BROUGHT YOUR CHILD TO THE DENTIST TODAY?

DOES YOUR CHILD REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT? YES NO

IS YOUR CHILD CURRENTLY IN PAIN? YES NO

HAS YOUR CHILD EVER HAD A SERIOUS PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK?

YES NO IF YES, WHAT?

HAS YOUR CHILD EVER HAD GUM TREATMENT? YES NO

HAS YOUR CHILD EXPERIENCED DISCOMFORT IN HIS/HER JAW (TMJ/TMD)? YES NO

DO YOUR CHILD'S GUMS EVER BLEED? YES NO

HOW MANY TIMES A WEEK DOES YOUR CHILD FLOSS? _____ TIMES A DAY HE/SHE BRUSHES?

TYPE OF BRISTLES? HARD MEDIUM SOFT

HOW LONG DOES YOUR CHILD USE A TOOTHBRUSH BEFORE REPLACING IT?

ARE YOUR CHILD'S TEETH SENSITIVE TO HEAT, COLD, OR ANYTHING ELSE? YES NO

HAS YOUR CHILD LOST ANY TEETH? YES NO

IF YES, WHY?

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

- | | |
|---|---|
| <input type="checkbox"/> ABNORMAL BLEEDING / HEMOPHILIA | <input type="checkbox"/> HANDICAPS / DISABILITIE |
| <input type="checkbox"/> ALCOHOL / DRUG ABUSE | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> ANY HOSPITAL STAYS | <input type="checkbox"/> HAY FEVER |
| <input type="checkbox"/> ANY OPERATIONS | <input type="checkbox"/> HEART ATTACK / SURGERY |
| <input type="checkbox"/> ARTIFICIAL BONES / JOINTS / VALVES | <input type="checkbox"/> HEART MURMUR |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> BLOOD TRANSFUSION | <input type="checkbox"/> KIDNEY PROBLEMS |
| <input type="checkbox"/> CANCER / CHEMOTHERAPY | <input type="checkbox"/> LIVER DISEASE |
| <input type="checkbox"/> COLITIS | <input type="checkbox"/> LOW BLOOD PRESSURE |
| <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> PSYCHIATRIC PROBLEMS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> RADIATION TREATMENT |
| <input type="checkbox"/> DIFFICULTY BREATHING | <input type="checkbox"/> RHEUMATIC /SCARLET FEVER |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> EPILEPSY / CONVULSIONS | <input type="checkbox"/> SICKLE CELL DISEASE / TRAITS |
| <input type="checkbox"/> FAINTING SPELLS | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> FREQUENT HEADACHES | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> HIV+ / AIDS | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> TUBERCULOSIS (TB) | <input type="checkbox"/> ULCERS |

ANYTHING YOU WOULD LIKE TO DISCUSS WITH THE DENTIST IN PRIVATE? YES NO

PLEASE LIST ANY OTHER SERIOUS MEDICAL CONDITION(S) THAT YOU HAVE EVER HAD:

I UNDERSTAND THAT 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.

SIGNATURE _____ DATE / /

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED. IF THIS OFFICE ACCEPTS INSURANCE, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AND ALSO RESPONSIBLE FOR PAYING ANY CO-PAYMENT AND DEDUCTIBLES THAT MY INSURANCE DOES NOT COVER. AS PARENT OR GUARDIAN OF THE CHILD RECEIVING TREATMENT, I AM RESPONSIBLE FOR PAYMENT. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL OFFICE OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORDS OF TREATMENT OR EXAMINATION RENDERED, TO MY INSURANCE COMPANY.

SIGNATURE _____ DATE / /