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.

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Tell Us About Your Child

Today's Date _____

Child's Name: _____
Last First MI

Nickname: _____ ❑ Male ❑ Female

Child's Birthdate: ___/___/___ Child's Age: _____

School: _____ Grade: _____

Child's Home Ph. #: _____

SS#: _____

Child's Home Address:

_____
Apt/Condo #

_____
City State Zip

Who is Accompanying the Child Today

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/Present Dentist: _____
Please Circle

Last visit date: _____

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

Mother's Information: [❑ Step Mother ❑ Guardian]

Name: _____

Home Ph #: _____

Work Ph #: _____ Ext: _____

Cell Ph #: _____

Employer: _____

Social Security # _____

Driver's Lic #: _____

Father's Information: [❑ Step Father ❑ Guardian]

Name: _____

Home Ph #: _____

Cell Ph #: _____

Work Ph #: _____ Ext: _____

Employer: _____

Social Security # _____

Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____
City State Zip

Home Ph #: _____

Work Ph #: _____ Ext: _____

Cell Ph #: _____

Employer: _____

Social Security # _____

Driver's Lic #: _____

Who is Responsible for Making Appointments?

Name: _____

Home Ph #: _____

Work Ph #: _____ Ext: _____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

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

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: _____ **& SS#:** _____

Insured's Employer: _____

Orthodontic Coverage? ❑ **Yes** ❑ **No**

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

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

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: _____ **& SS#:** _____

Insured's Employer: _____

Orthodontic Coverage? ❑ **Yes** ❑ **No**

Why Did You Bring the Child to the Dentist Today?

_____

_____

Has the child ever had a serious/difficult problem associated with previous 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 pain / tenderness in their jaw joint (TMJ TMD)? ❑ Yes ❑ No

Does the child brush their teeth daily? ❑ Yes ❑ No

Floss their teeth daily? ❑ Yes ❑ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

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

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

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

_____

_____

Please list all the drugs that the child is allergic to: _____

_____

_____

Has the child ever had any of following medical problems?

❑Yes	❑No	Heart Murmur	❑Yes	❑No	Congenital Heart Defect
❑Yes	❑No	Cancer	❑Yes	❑No	Convulsions/Epilepsy
❑Yes	❑No	Diabetes	❑Yes	❑No	Abnormal Bleeding
❑Yes	❑No	Rheumatic Fever	❑Yes	❑No	Hearing Impairment
❑Yes	❑No	HIV+/AIDS	❑Yes	❑No	Any Operations
❑Yes	❑No	Hemophilia	❑Yes	❑No	Any Stays in Hospital
❑Yes	❑No	Asthma	❑Yes	❑No	Kidney/Liver Problems
❑Yes	❑No	Hepatitis	❑Yes	❑No	Handicaps/Disabilities
❑Yes	❑No	Tuberculosis (TB)	❑Yes	❑No	Allergies to any drugs

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

_____

_____

Has the child ever had any of following habits?

❑Yes ❑No Thumb/Finger Sucking

❑Yes ❑No Lip Sucking/Biting

❑Yes ❑No Nail Biting

❑Yes ❑No Nursing Bottle Habits

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

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. **I also authorize the dental staff to perform the necessary dental services my child may need.**

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved. In the event that the account becomes delinquent for more than 60 days, I agree to pay a finance charge of 1.5% per month on any balance due, as well as all collection costs, court costs, attorney fees, and interest fee accrued with the collection of this account.

_____ _____

Signature of parent or guardian Date