Welcome!

Tell Us About Your Child

Today's Date: _____ Child's Home Phone #: (____)_____ Social Security #: _____

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

Nickname: _____ ❑ Male ❑ Female School: _____ Grade: _____

Child's Home Address: _____
Street City State Zip

Whom may we thank for referring you? _____

Parent's Information

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

Mother Birthdate: ____/____/____ Home Phone #: (____)_____ Work Phone #: (____) _____

Name: _____ Social Security #: _____ Driver's License #: _____

Address: _____
Street City State Zip

Employer: _____ Length of Employment: _____

Father Birthdate: ____/____/____ Home Phone #: (____)_____ Work Phone #: (____) _____

Name: _____ Social Security #: _____ Driver's License #: _____

Address: _____
Street City State Zip

Employer: _____ Length of Employment: _____

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
PO Box/Street City State Zip

Insured's Name: _____ Relationship to Patient: _____

Insured's Birthdate: ____/____/____ Social Security #: _____ Insured's Employer: _____

Employer's Address: _____
Street City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
PO Box/Street City State Zip

Insured's Name: _____ Relationship to Patient _____

Insured's Birthdate: ____/____/____ Social Security #: _____ Insured's Employer: _____

Employer's Address: _____
Street City State Zip

CONTINUED ON BACK

Dental History

Is the child currently in pain? ❑ **Yes** ❑ **No** **What is the primary reason for today's visit?** _____

Has the child experienced problems with previous dental work? ❑ Yes ❑ No

Does the child brush his / her teeth daily? ❑ Yes ❑ No

Floss his / her teeth daily? ❑ Yes ❑ No

Previous / Present Dentist: _____ Date of Last Visit _____
(Please Circle)

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least? _____

Does / did the child have 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 Breather
- ❑ Speech Problems
- ❑ Breast Fed

Medical History

Child's Physician: _____ Phone #: (____)_____ Date of last visit: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? ❑ Yes ❑ No Please explain: _____

Please describe the child's current physical health: ❑ Good ❑ Fair ❑ Poor **Are Immunizations Current?** ❑ Yes ❑ No

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

Please list all drugs and/or things that cause the child allergic reactions:

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

Has the child had/experienced any of the following:

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

Please discuss any serious medical problems the 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 insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

_____
Signature Date