

Today's Date: \_\_\_\_\_

*NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.*

## 1 TELL US ABOUT YOUR CHILD

Child's Name: \_\_\_\_\_  
Last First Middle

Goes by: \_\_\_\_\_  Male  Female

Siblings that we treat: \_\_\_\_\_

Child's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age: \_\_\_\_\_

School: \_\_\_\_\_

Child's Home #: (\_\_\_\_) \_\_\_\_\_

SSN: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

City State Zip

## 2 MOTHER'S INFORMATION

Name: \_\_\_\_\_

Mother Stepmother Guardian Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City State Zip

Employer: \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_

SSN: \_\_\_\_\_ DL#: \_\_\_\_\_

Email Address: \_\_\_\_\_

## 3 FATHER'S INFORMATION

Name: \_\_\_\_\_

Father Stepmother Guardian Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City State Zip

Employer: \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_

SSN: \_\_\_\_\_ DL#: \_\_\_\_\_

Email Address: \_\_\_\_\_

## 4 WHO MAY WE THANK FOR REFERRING YOU?

## 5 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Do you have legal custody of this child?  YES  NO

## 6 PERSON RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City State Zip

Work #: (\_\_\_\_) \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

## 7 PRIMARY DENTAL INSURANCE

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City State Zip

Insurance Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

## 8 SECONDARY DENTAL INSURANCE

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City State Zip

Insurance Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

## 9 DENTAL HISTORY

Is this your child's first visit to the dentist? \_\_\_\_\_

If not, how long since the last visit to the dentist? \_\_\_\_\_

Previous dentist's name: \_\_\_\_\_

Were any x-rays taken at previous dental visits? \_\_\_\_\_

Have there been any injuries to the teeth, face or mouth? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why did you bring your child to the dentist today? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the child have any of the following habits?

Y  N Lip Sucking / Biting       Y  N Nail Biting  
 Y  N Nursing / Bottle Habits       Y  N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work?       YES       NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Is the child's water fluoridated?       YES       NO

Is the child taking fluoride supplements?       YES       NO

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)?       YES       NO

Does the child brush his/her teeth daily?       YES       NO

Floss his/her teeth daily?       YES       NO

**11** I understand that the information 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 authorize the dental staff to perform the necessary dental services my child may need.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

### FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials \_\_\_\_\_ Date \_\_\_\_\_

## 10 HEALTH HISTORY

Has the child ever had any of the following conditions?

<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities
<input type="checkbox"/> Y <input type="checkbox"/> N Allergies to any Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment
<input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease/Murmur
<input type="checkbox"/> Y <input type="checkbox"/> N Any Operations	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N HIV + / AIDS
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney/Liver Conditions
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Birth Defects	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Latex Product
<input type="checkbox"/> Y <input type="checkbox"/> N Pregnancy	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes
<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Blood Disorders
<input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHD	<input type="checkbox"/> Y <input type="checkbox"/> N Reflux/GI Problems

Please discuss any serious medical conditions the child has had:  
\_\_\_\_\_  
\_\_\_\_\_

Please list all the drugs the child is currently taking: \_\_\_\_\_  
\_\_\_\_\_

Please list all drugs the child is allergic to: \_\_\_\_\_  
\_\_\_\_\_

Child's Physician: \_\_\_\_\_

Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Is the child currently under the care of a physician?       YES       NO

Please describe the child's current physical health:

GOOD       FAIR       POOR

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