

# 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.

## 1. Tell Us About Your Child

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

Child's Full Name \_\_\_\_\_

Nickname \_\_\_\_\_  M  F

Birthdate \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ SS# \_\_\_-\_\_\_-\_\_\_

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

Hm # \_\_\_\_\_ Grade \_\_\_\_\_

School \_\_\_\_\_

## 2. Who Is Accompanying The Child

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 Dentist \_\_\_\_\_

Last visit date \_\_\_\_\_ Last x-ray date \_\_\_\_\_

Parent's marital status  Single  Married  Divorced  
 Widowed  Separated

## 3. Parent's Information

Mother  Stepmother  Guardian

Name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_

Wk # \_\_\_\_\_ ext \_\_\_\_\_ Hm # \_\_\_\_\_

Employer \_\_\_\_\_

SS # \_\_\_\_\_ DL # \_\_\_\_\_

Father  Stepfather  Guardian

Name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_

Wk # \_\_\_\_\_ ext \_\_\_\_\_ Hm # \_\_\_\_\_

Employer \_\_\_\_\_

SS # \_\_\_\_\_ DL # \_\_\_\_\_

## 4. Person Responsible for Account

Name \_\_\_\_\_ Relation \_\_\_\_\_

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

Hm # \_\_\_\_\_ Wk # \_\_\_\_\_ ext \_\_\_\_\_

Employer \_\_\_\_\_

SS# \_\_\_\_\_ DL# \_\_\_\_\_

**Who is responsible for making appointments?**

Name \_\_\_\_\_

Hm # \_\_\_\_\_ Wk # \_\_\_\_\_ ext \_\_\_\_\_

## 5. Dental Insurance Information

### PRIMARY DENTAL INSURANCE

Insurance Co Name \_\_\_\_\_

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

Insurance Co Phone # \_\_\_\_\_

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

**Policy Owner's Name** \_\_\_\_\_

Relation to Patient \_\_\_\_\_

**Policy Owner's Birthdate** \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

**Policy Owner's Employer** \_\_\_\_\_

### SECONDARY DENTAL INSURANCE

**WE NO LONGER FILE SECONDARY INSURANCE.**

## 6. The Child's Medical History

Current physical health is  Good  Fair  Poor

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

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

Please list all prescription / over-the-counter medications that the child is currently taking \_\_\_\_\_

### Has the child ever had any of the following medical conditions?

Y N Abnormal Bleeding	Y N Herpes/Fever Blisters
Y N Anemia	Y N HIV+ / AIDS
Y N Asthma	Y N Hospital Stay
Y N Blood Transfusion	Y N Joint Replacement
Y N Cancer/Chemotherapy	Y N Kidney Problems
Y N Chicken Pox	Y N Learning Disabilities
Y N Congenital Heart Defect	Y N Liver Disease
Y N Diabetes	Y N Mitral Valve Prolapse
Y N Difficulty Breathing	Y N Operations
Y N Epilepsy	Y N Psychiatric Problems
Y N Fainting Spells	Y N Radiation Treatment
Y N Frequent Headaches	Y N Rheumatic Fever
Y N Hay Fever	Y N Seizures
Y N Hearing Impaired	Y N Shingles
Y N Heart Murmur	Y N Sickle Cell Disease
Y N Heart Surgery	Y N Sinus Problems
Y N Hemophilia	Y N Tuberculosis (TB)
Y N Hepatitis	

Please list any other medical conditions that the child has ever had \_\_\_\_\_

### Is the child allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other
Y N Dental Anesthetic	Y N Penicillin	

Please list any other medications/food that the child is allergic to \_\_\_\_\_

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

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

Phone # \_\_\_\_\_ Last Visit Date \_\_\_\_\_

## 7. The Child's Dental History

Why did you bring the child to the dentist today?

\_\_\_\_\_

\_\_\_\_\_

Does the child need to be premedicated before dental treatment?  Yes  No

Is the child currently in pain?  Yes  No

Has the child ever had a serious / difficult problem associated with any previous dental work?  Yes  No

Has the child ever experienced pain / discomfort / in his / her jaw joint (TMJ / TMD) ?  Yes  No

Current dental health is  Good  Fair  Poor

Floss daily?  Yes  No Brush Daily?  Yes  No

Type of Bristles on child's toothbrush?  Hard  Medium  Soft

How long does the child use his / her toothbrush before replacing it? \_\_\_\_\_

Does the child use anything in addition to brush and floss?

If yes, what? \_\_\_\_\_

Does the child's gums ever bleed?  Yes  No

Are his / her teeth sensitive to heat or cold?  Yes  No

Are his / her teeth sensitive to sweets?  Yes  No

Are his / her teeth sensitive to chewing ?  Yes  No

Has the child lost any teeth accidentally?  Yes  No

If yes, how? \_\_\_\_\_

Has the child had orthodontic treatment?  Yes  No

If yes, when? \_\_\_\_\_

Is the child's water Fluoridated?  Yes  No

Does / did the child have any of the following habits?

Y N Lip Sucking / Biting	Y N Nursing Bottle Habit
Y N Nail Biting	Y N Thumb Sucking
Y N Tongue / Cheek Biter	Y N Mouth Breather
Y N Clenching / Grinding Teeth	Y N Speech Problems
Y N Used Pacifier	Y N Breast Fed

### I understand

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. I authorize the dental staff to perform the necessary dental services that my child may need.

Signature \_\_\_\_\_

Date \_\_\_\_\_