Welcome!

Tell Us About Your Child

Today's date: __________ Child's Home Phone: (____) __________ Social Security #: __________

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

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 ____________

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 ❑ Clenching/Grinding Teeth ❑ Tongue/Cheek Biting ❑ Mouth Breather
❑ Nail Biting ❑ Thumb/Finger Sucking ❑ Used Pacifier ❑ Speech Problems
❑ Chewing on Objects ❑ Nursing Bottle Habits ❑ Tongue Thrust ❑ 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 ❑ Congenital Heart Defect ❑ High Blood Pressure ❑ Rheumatic Fever
❑ AIDS/HIV+ ❑ Convulsions ❑ Hives ❑ Scarlet Fever
❑ Allergies ❑ Diabetes ❑ Kidney Problems ❑ Sickle Cell Anemia
❑ Anemia ❑ Epilepsy ❑ Liver Problems ❑ Skin Rash
❑ Any Hospital Stay/Operations ❑ Handicaps/Disabilities ❑ Low Blood Pressure ❑ Tonsillitis
❑ Asthma ❑ Hearing Impairment ❑ Lupus ❑ Tuberculosis (TB)
❑ Blood Transfusion ❑ Heart Murmur ❑ Measles
❑ Cancer ❑ Hemophilia ❑ Mitral Valve Prolapse
❑ Chicken Pox ❑ Hepatitis ❑ Mononucleosis

Please discuss any serious medical problems the child experiences/ed: ____________

____

Authorization

Acknowledgement of Receipt of Private Practices Notice

I, ____________, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: ____________ Date: ____________

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: ____________

Relationship to Individual: ____________

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