Welcome to our Practice!

Your Child

Child's Name _____ ☐ Male ☐ Female

Child's preferred name: _____

Child's Date of Birth: _____

School: _____

Name and ages of other children in the family: _____

Who may we thank for referring you to our office? _____

Parent or Guardian Information ☐ Mother/Father ☐ Stepmother/Stepfather ☐ Guardian

Name _____ Address _____

City_____State_____Zip_____

Email _____ Phone - Home_____Cell_____Work_____

Employer _____ Occupation_____SS# _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Parent or Guardian Information ☐ Mother/Father ☐ Stepmother/Stepfather ☐ Guardian

Name _____ Address _____

City_____State_____Zip_____

Email _____ Phone - Home_____Cell_____Work_____

Employer _____ Occupation_____SS# _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Responsible Party

Who is responsible for making appointments? _____

Who is responsible for payment of services? _____

Primary Dental Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS# _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Subscriber #_____

Ins. Co. Address _____ City _____ State _____ Zip _____

Additional Dental Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS# _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Subscriber #_____

Ins. Co. Address _____ City _____ State _____ Zip _____

Please complete opposite side.

Medical History

Has your child ever had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV+	☐	☐	Drug or Alcohol Abuse	☐	☐	Rheumatoid Arthritis
☐	☐	Attention Deficit/Hyperactivity	☐	☐	Epilepsy/Seizures	☐	☐	Scarlet Fever
☐	☐	Anemia	☐	☐	Endocrine/Growth Disorders	☐	☐	Scoliosis
☐	☐	Allergies	☐	☐	Eye Problems	☐	☐	Sickle Cell Anemia
☐	☐	Asthma or Lung Problems	☐	☐	Fainting/Dizziness	☐	☐	Sinus Problems/Snoring
☐	☐	Autism	☐	☐	Hearing Loss	☐	☐	Sore Throat (frequent)
☐	☐	Bleeding Abnormalities	☐	☐	Heart Disease/Murmur	☐	☐	Enlarged Tonsils/Adenoids
☐	☐	Brain Injury	☐	☐	Hemophilia	☐	☐	Spina Bifida
☐	☐	Cancer/Tumors	☐	☐	Hepatitis	☐	☐	Tuberculosis
☐	☐	Cerebral Palsy	☐	☐	Leukemia			
☐	☐	Cleft Lip/Palate	☐	☐	Intellectual Disability			
☐	☐	Developmental Delay	☐	☐	Pregnancy			
☐	☐	Diabetes	☐	☐	Psychiatric Disorder			

Please explain any checked items/other health conditions:_____

_____

_____

_____

Home Care & Dental History

How often does your child brush? _____ Floss? _____

Is brushing/flossing supervised? ☐ Yes ☐ No By Whom? _____

Is the child's water fluoridated? ☐ Yes ☐ No ☐ Don't Know

Is your child receiving fluoride supplements? ☐ Yes ☐ No

☐ Tablets ☐ Drops ☐ Other _____

Is this your child's first dental visit? ☐ Yes ☐ No

Previous Dentist & City _____

Date of last visit _____ Date of last dental x-rays _____

Any injuries to your child's teeth or jaw? ☐ Yes ☐ No

When/What? _____

Has your child had recent dental pain? ☐ Yes ☐ No

Please Explain _____

☐ Breast-feeding (until age) _____ ☐ Bottle (until age) _____

☐ Thumb/Finger Sucking (until age) _____ ☐ Pacifier (until age) _____

☐ Dental Grinding/Clenching ☐ Mouthbreathing/Snoring

Has your child experienced any unfavorable reaction from previous medical or dental care? ☐ Yes ☐ No Please Explain _____

_____

Child's Physician _____ Phone _____

Address _____

Please list all medications the child is currently taking (Give reasons) _____

_____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, etc.)? ☐ Yes ☐ No

(if yes, please describe) _____

Does your child require premedication prior to dental treatment? ☐ Yes ☐ No Why ? _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)?_____

Is your child under the care of a specialist for any medical reason? ☐ Yes ☐ No Why ? _____

Specialist's Name _____ Phone _____

Please list any serious medical problem, hospitalizations, surgeries the child has had _____

_____

Do you wish to speak to the doctor privately about a special concern? ☐ Yes ☐ No

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental 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. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of Patient (or Parent/Guardian if minor) Date