

Dental History

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

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? Yes No

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

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? 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 about? _____

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

- | | | |
|------------------------------|---------------------------|--------------------------|
| Y N Breast Fed | Y N Mouth Breather | Y N Thumb/Finger Sucking |
| Y N Chewing on Objects | Y N Nail Biting | Y N Tongue/Cheek Biting |
| Y N Clenching/Grinding Teeth | Y N Nursing Bottle Habits | Y N Tongue Thrust |
| Y N Lip Sucking/Biting | Y N Speech Problems | Y N Used Pacifier |

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 other 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:

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

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

Medical History

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It 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 my child may need. My method of payment will be _____.

 Signature of parent or guardian

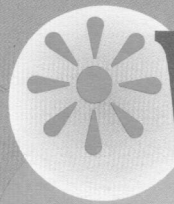
 Date

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

 Signature of parent or guardian

 Date

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



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

Who Is Accompanying The Child Today?

Name: _____ Relation: _____
 Do you have legal custody of this child? Yes No Is the child adopted? Yes No Is the child in a foster home? Yes No
 Whom may we Thank for referring you? _____ Other siblings seen by us: _____

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____
 Address: _____
Street City State Zip

Parent's Information

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

Mother: Step Mother Guardian Birthdate: ____/____/____ Home Phone #: (____) _____ Work Phone #: (____) _____
 Name: _____ Social Security #: _____ Driver's License #: _____
 Address: _____
Street City State Zip
 Employer: _____ Length of Employment: _____

Father: Step Father Guardian Birthdate: ____/____/____ Home Phone #: (____) _____ Work Phone #: (____) _____
 Name: _____ Social Security #: _____ Driver's License #: _____
 Address: _____
Street City State Zip
 Employer: _____ Length of Employment: _____

Person Responsible for Account

Name: _____ Relationship: _____ Social Security #: _____
 Billing Address: _____
Street City State Zip
 Work Phone #: (____) _____ Home Phone #: (____) _____ Employer: _____ Driver's License #: _____

Who is responsible for making appointments?

Name: _____ Work Phone #: (____) _____ Home Phone #: (____) _____ Best time to call: _____

Insurance Information

Dental Coverage? Yes No Medical Coverage? Yes No Orthodontic Coverage? Yes No
 Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local, or Policy #): _____
 Insurance Co. Address: _____
PO Box/Street City State Zip
 Policy Owner's Name: _____ Relationship to Patient: _____
 Policy Owner's Birthdate: ____/____/____ Social Security #: _____ Policy Owner's Employer: _____
 Employer's Address: _____
Street City State Zip

Dental Coverage? Yes No Medical Coverage? Yes No Orthodontic Coverage? Yes No
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Street City State Zip