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

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 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: _____

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: _____ (Last / First / MI) Child's Birthdate: ____/____/____ Child's Age: _____

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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Employer's Address: _____ (Street / City / State / Zip)

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