Welcome

Tell Us About Your Child

Today's Date_____

Child's Name:_____
Last First MI

Child's Birthdate: ____/ ____/ ____ Child's Age: _____

Nickname:_____ ____Male ____Female

School: _____ Grade:_____

Child's Home #: (____)_____ SS#: _____

Child's Home Address: _____

_____
City State Zip

Email Address: _____

Person Responsible for Account

Name: _____ Relation:_____

Billing Address: _____

_____
City State Zip

WK#: (____)_____ Ext: _____ HM#: (____)_____

Employer: _____

DL#: _____ SS#: _____

Who is responsible for making appointments?

Name: _____

WK#: (____)_____ Ext:_____ HM#: (____)_____

Who is Accompanying The Child Today?

Name:_____ Relation:_____

Do you have legal custody of this child? ___Yes ___No

Is child adopted? ___Yes ___No Is child in a foster home? ___Yes ___No

Whom may we thank for referring you? _____

Other siblings seen by us: _____

Previous / Present Dentist: _____

(Please Circle)

Last Visit Date: _____

Parent's Marital Status ___Single ___Widowed ___Partnered ___Married ___Divorced ___Separated

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/ ____/ ____ ID#: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ____Yes ____No

Parent's Information

____Mother ____Step Mother ____Guardian

Name:_____ Birthdate: ____/ ____/ ____ Email Address: _____

Cell#: (____)_____ Hm#: (____)_____ Employer: _____ Wk#: (____)_____

SS#: _____ DL#: _____

____Father ____Step Father ____Guardian

Name: _____ Birthdate: ____/ ____/ ____ Email Address: _____

Cell#: (____)_____ Hm#: (____)_____ Employer:_____ Wk#: (____)_____

SS#: _____ DL#: _____

Why did you bring the child to the dentist today?

_____

_____

_____

Has the child ever had a serious/difficult problem associated with previous dental work? ___Yes ___No

Is the child's water fluoridated? ___Yes ___No

Is the child taking fluoridated supplements? ___Yes ___No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ___Yes ___No

Does the child brush his / her teeth daily? ___Yes ___No

Floss his / her teeth daily? ___Yes ___No

Child's Physician: _____

Phone #: (____)_____ Date of Last Visit: _____

Is the child currently under the care of a physician? ___Yes ___No

Please describe the child's current physical health:

___Good ___Fair ___Poor

Has the child ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? ___Yes ___No

Please list all drugs that the child is currently taking:

_____

_____

Aside from items listed below, list all drugs / things the child is allergic to:

_____

_____

Latex ___Yes ___No **Metals/Nickel** ___Yes ___No **Plastic** ___Yes ___No

Has the child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Handicaps / Disabilities
Y	N	ADD / ADHD	Y	N	Hearing Impairment
Y	N	Anemia	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Valves	Y	N	Hives
Y	N	Asthma	Y	N	HIV+/AIDS
Y	N	Cancer	Y	N	Kidney/Liver Problems
Y	N	Chicken Pox	Y	N	Measles
Y	N	Congenital Heart Defect	Y	N	Mononucleosis
Y	N	Convulsions	Y	N	Rheumatic/Scarlet Fever
Y	N	Diabetes	Y	N	Sickle Cell Disease/Traits
Y	N	Epilepsy	Y	N	Skin Rash
Y	N	Exposed to HIV, but Neg.	Y	N	Tuberculosis (TB)

Are the Child's Immunizations current? ___Yes ___No

Anything you would like to discuss with the Doctor in private? ___Yes ___No

Please discuss any serious medical problems that the child has had:_____

_____

Does/did the child experience any of the following?

Y	N	Lip Sucking/Biting	Y	N	Nursing Bottle Habits
Y	N	Nail Biting	Y	N	Thumb/Finger Sucking

Was the child breast fed? ___Yes ___No

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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 times of service unless prior arrangements have been approved.

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I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein. Initials: _____ Date: _____

Doctor's Comments:

_____

_____

_____

_____