1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nickname: _____ ☐ Male ☐ Female

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

School: _____ Grade: _____

Child's Home #: _____ SS #: _____

Child's Home Address: _____

APT/CONDO #

_____

CITY STATE ZIP

2 Who is accompanying the child today?

Name: _____

Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we **Thank** for referring you: _____

Other family members seen by us: _____

_____

Previous / Present Dentist: _____

Last visit date: _____

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

3 Mother's Information ☐ Step Mother ☐ Guardian

Name: _____

Wk #: _____ Ext.: _____ Hm #: _____

Employer: _____

SS #: _____ DL #: _____

Father's Information ☐ Step Father ☐ Guardian

Name: _____

Wk #: _____ Ext.: _____ Hm #: _____

Employer: _____

SS #: _____ DL #: _____

4 Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____

Wk #: _____ Ext.: _____ Hm #: _____

SS #: _____ DL #: _____

Who is responsible for making appointments?

Name: _____

Wk #: _____ Ext.: _____ Hm #: _____

5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Phone #: _____

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

Insured's Name: _____

Relationship to patient: _____

Insured's Birthday: ____/____/____ SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Phone #: _____

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

Insured's Name: _____

Relationship to patient: _____

Insured's Birthday: ____/____/____ SS#: _____

Insured's Employer: _____

6 Has the child ever had the following medical problems?

(Circle "Y" or "N")

Y	N	Heart Murmur	Y	N	Mitrovalve Prolapse
Y	N	Cancer	Y	N	Congenital Heart Defect
Y	N	Diabetes	Y	N	Convulsions / Epilepsy
Y	N	Rheumatic Fever	Y	N	Abnormal Bleeding
Y	N	HIV+/AIDS	Y	N	Hearing Impairment
Y	N	Hemophilia	Y	N	Any Operations
Y	N	Asthma	Y	N	Any stays in a hospital
Y	N	Hepatitis	Y	N	Kidney / Liver Problems
Y	N	Tuberculosis	Y	N	Handicaps / Disabilities
Y	N	Allergies to any drugs			

Please discuss any medical problems that the child has had:

_____

_____

_____

_____

7 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 supplement? ☐ Yes ☐ No

Does the child brush their teeth daily? ☐ Yes ☐ No

Floss their teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Last Visit Date: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Describe the child's current health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking: _____

_____

_____

Please list all drugs/latex that the child is allergic to: _____

_____

_____

8 Does the child have the following habits?

(Circle "Y" or "N")

Y N Thumb / Finger Sucking

Y N Lip Sucking / Biting

Y N Nail Biting

Y N Nursing Bottle Habits

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

9

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of insurance coverage. The patient agrees that in the event of any default in payment of account patient will be liable for attorneys fees and cost of collection which includes a 15% service fee.

_____

Signature

_____

Date