

Welcome To Our Practice!!

We want to welcome your child into our practice. Our goal is to make his/her dental experience pleasant and educational. Please provide us with all information requested so we can better understand and care for your child.

Patient Name: _____ Nickname: _____ Sex: _____
Last First MI

Birthday: _____ Age: _____ Siblings & Ages _____

Home Phone: () _____ School: _____ Grade: _____ Weight: _____

Home Address: _____
Street Apt No.

City State Zip

Reason for visit: _____

Health Information - Has your child ever had difficulty with any of the following: (Please check all that apply)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles/Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Vision Disorders |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Hearing Disorders | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Other |

Please describe all above conditions that apply: _____

	Yes	No
Is your child in good health?	___	___
Are immunizations up-to-date?	___	___
Is your child taking any medicines or drugs:	___	___
Has your child ever been hospitalized or had surgery?	___	___
Does your child have a heart murmur or condition requiring Prophylactic Antibiotic coverage before dental treatment	___	___
Does your child have any allergies (drugs or latex)	___	___
If yes, please specify: _____		

Child's Pediatrician _____ Last Visit: _____ Phone: _____

Has your child been seen by another dentist? _____ If yes, name: _____

Date of last visit: _____ Phone: _____ X-rays: _____

Has your child ever had an unfavorable dental experience? _____

How often does your child brush (i.e. once per day, twice per day): _____

Who is responsible for teeth cleaning? Child Parent Both

Was your child breast fed? Bottle fed? Age discontinued? _____

Does your child: (Please check all that apply)

Suck thumb/Finger Suck/Bite lips Grind teeth Pacifier

Bite/Chew nails Chew hard objects Clench jaw

What is your home water source? Public system Private well Other _____

Because your child is a minor, it is necessary that signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment is performed. The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate there to. This consent shall remain in full force and effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment should named responsible party fail or insurance benefits be denied.

Signature of Parent of Guardian: _____ Date: _____

Office Use

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

Who is Accompanying the Child today?

Name: _____ Relationship: _____

Do you have legal custody of this child? _____ Is your child adopted? _____

Child lives with: ___Both parents ___Mom ___Dad ___Grandparent ___Guardian

I have listed below two persons who might be involved in his/her dental updates and/or transportation.

1. _____ 2. _____

Parent (or Guardian) Information

Father's Name: _____

Mother's Name: _____

DOB: _____

DOB: _____

Soc. Sec. # _____

Soc. Sec. # _____

Home address if different from child: _____

Home address if different from child: _____

Home #: _____

Home #: _____

Work #: _____

Work #: _____

Cell/Pager #: _____

Cell/Pager #: _____

Employer: _____

Employer: _____

Occupation: _____

Occupation: _____

Marital Status: ___Single ___Married

Marital Status: ___Single ___Married

___Divorced ___Widowed

___Divorced ___Widowed

Emergency Information

Name _____ Relationship _____ Phone _____

Person Responsible for Account

Name: _____ Relationship: _____

Billing address _____

Home phone _____ Work _____ Cell _____

DL# _____ SS# _____

Primary Insurance Information

Name of Insured: _____

Insured Date of Birth: _____ ID No. _____ Group No. _____

Insured's address _____

Insured's Employer Name _____

Employer address _____

Patients relationship to insured: ___self ___Spouse ___Child ___Other _____

Insurance plan name _____ phone _____

Insurance plan address _____

Referral Information – who can we thank for referring you to our office?

___another patient ___dental office ___pediatrician ___yellow pages ___website ___newspaper ___school ___work

___other _____ Name of office referring you to our practice _____

I authorize the dentist to release any information to third party payers and /or other health practitioners, if necessary. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me.

Signed: _____ Date: _____