

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that last a lifetime.

1 Tell us about your child

Today's Date _____

Child's Name _____
LAST FIRST M. INITIAL

Child's Birthdate _____ Child's Age _____

Nickname _____ Male Female

School _____ Grade _____

Hobbies/Sports _____

Child's Home # _____ SS# _____

Child's Home Address _____
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? _____

List brothers /sisters with age _____

General Dentist _____

Last Exam Date _____ Any Cavities? _____

Parent's Marital Status Single Widowed Married
 Divorced Separated

3 Parent's Information

Mother Step Mother Guardian

Name _____ Birthdate _____

Check which number is best to contact you.

Home Work Cell _____

Employer _____

How long at your current job? _____ Job Title? _____

SS# _____ DL# _____

Email _____

Father Step Father Guardian

Name _____ Birthdate _____

Check which number is best to contact you.

Home Work Cell _____

Employer _____

How long at your current job? _____ Job Title? _____

SS# _____ DL# _____

Email _____

4 Person Responsible for account

Name _____ Relation _____

Billing Address _____
CITY STATE ZIP

Previous Address _____

Hm# () _____ DL# _____

Employer _____

Wk# () _____ Ext. _____ SS# _____

Who is responsible for making appointments?

Name _____ Birthdate _____

Wk# () _____ Ext. _____ Hm# _____

Neighbor of relative not living with you

Name _____ Phone _____

Address _____
CITY STATE ZIP

5 Primary Dental Insurance

Dental Coverage? Yes No Ortho Coverage? Yes No

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 _____ S.S# _____

Policy Owners Employer _____

Secondary Insurance

Dental Coverage? Yes No Ortho Coverage? Yes No

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 _____ S.S# _____

Policy Owners Employer _____

All accounts sent to collections will be charged the account balance plus an additional 50%, based on the account balance.

6 Why do 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
- Does the child brush his/her teeth daily? Yes No
- Floss His/Her teeth daily? Yes No
- Has the child ever had any pain/tenderness in his/her jaw joint (TMI/TMD)? Yes No
- Has your child ever had trauma to the mouth or teeth? Yes No

Chief Complaint: _____

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

Please list all drugs that the child is currently taking:

Is your child allergic to any of the following drugs?

- Penicillin Erythromycin Tetracycline
- Dental Anesthetics Aspirin Latex

Other, Specify: _____

Comments: _____

9 I affirm that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of 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.

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 and all my insurance submissions, whether manual or electronic. Should the account be referred to any attorney for collection, the undersigned shall pay reasonable attorney's fees and expenses.

SIGNATURE OF PARENT OR GUARDIAN DATE

We reserve the right to charge for any broken or cancelled appointment without a minimum of 48 hours notice.

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally retrieved the medical / dental information above with the parent/guardian & patient named herein.

Doctor's Comments _____ Initials _____ Date _____

7 Has your child ever had any of the following medical problems:

- Y N Abnormal Bleeding Y N Heart Murmur
- Y N Anemia Y N Heart problems of any kind
- Y N Any hospital stays Y N Hemophilia
- Y N Any operations Y N Hepatitis
- Y N Attention Deficit Disorder Y N Kidney/ Liver Problems
- Y N Asthma Y N Positive HIV+/ AIDS
- Y N Cancer/chemotherapy Y N Psychiatric Problems
- Y N Convulsions Y N Rheumatic/Scarlet Fever
- Y N Diabetes Y N Spina Bifida
- Y N Ear Infections Y N Throat Infections
- Y N Fever Blisters Y N Tuberculosis (TB)
- Y N Handicaps/Disabilities
- Y N Hearing Impairment

Are the child's immunizations correct? Yes No

Has your child been hospitalized for any surgery or medical conditions? 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: _____

8 Does/did the child have any of the following

- Y N Lip Sucking/Biting Y N Uses bottle or pacifier
- Y N Mouth Breather Y N Thumb/ Finger Sucking
- Y N Nail Biting Y N Grinding teeth at night
- Y N Protruding tongue

Other, Specify _____