



# WELCOME TO THE DENTIST



*Our goal is to help your child reach and maintain good oral health and a beautiful smile that lasts a lifetime.*

**1**

## Tell Us About Your Child

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
LAST FIRST MI

Nickname: \_\_\_\_\_  M  F

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS #: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies / Sports: \_\_\_\_\_

Child's Home # (\_\_\_\_) \_\_\_\_\_

Child's Home Address: \_\_\_\_\_  
CITY STATE ZIP

**2**

## Who is Accompanying Your Child Today?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

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

Do you have legal custody of this child?  Yes  No

Whom may we thank for referring you? \_\_\_\_\_

List other family members seen by us \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

Date of last cleaning / visit: \_\_\_\_\_

**3**

## Parental Information

Mother  Stepmother  Guardian

Name: \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Wk # (\_\_\_\_) \_\_\_\_\_ Hm # (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

How long at current job: \_\_\_\_\_ Job Title: \_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

Father  Stepfather  Guardian

Name: \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Wk # (\_\_\_\_) \_\_\_\_\_ Hm # (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

How Long at Current Job: \_\_\_\_\_ Job Title: \_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

**4**

## Person Responsible for Account

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
CITY STATE ZIP

Previous Address: \_\_\_\_\_

Hm # (\_\_\_\_) \_\_\_\_\_ DL #: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk # (\_\_\_\_) \_\_\_\_\_ SS #: \_\_\_\_\_

**Who is responsible for making appointments?**

Name: \_\_\_\_\_

Wk # (\_\_\_\_) \_\_\_\_\_ Hm # (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

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## Primary Dental Insurance

Dental Coverage?  Y  N Orthodontic Coverage?  Y  N

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: \_\_\_\_\_

## Secondary Dental Insurance

Dental Coverage?  Y  N Orthodontic Coverage?  Y  N

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: \_\_\_\_\_





### Why did you bring your child to the dentist today?

Has your child ever been evaluated or had dental treatment before?  Y  N

Has your child ever had a serious / difficult problem associated with previous dental work?  Y  N

Have there been any injuries to the face, mouth, teeth or chin?  Y  N

List any musical instruments played: \_\_\_\_\_

Have adenoids or tonsils been removed?  Y  N

Has your child been informed of any missing or extra permanent teeth?  Y  N

**Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)?**  Y  N

Does your child brush his / her teeth daily?  Y  N

Does your child floss his / her teeth daily?  Y  N

Child's Physician: \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

**Is your child under the care of a physician?**  Y  N

Has puberty begun?  Y  N

**Girls** - Has menstruation begun?  Y  N

**Please describe your child's current physical health:**  Good  Fair  Poor

Please list all drugs that your child is currently taking:

\_\_\_\_\_

Please list all drugs/things that your child is allergic to:

\_\_\_\_\_

Latex Y N      Metals / Nickel Y N      Plastics Y N



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

- |                                |                               |
|--------------------------------|-------------------------------|
| Y N Abnormal Bleeding          | Y N Convulsions / Epilepsy    |
| Y N ADD / ADHD                 | Y N Diabetes                  |
| Y N Allergies to Any Drugs     | Y N Handicaps / Disabilities  |
| Y N Allergic to Latex / Metals | Y N Hearing Impairment        |
| Y N Allergic to Plastic        | Y N Heart Murmur              |
| Y N Any Hospital Stays         | Y N Hemophilia                |
| Y N Any Operations             | Y N Hepatitis                 |
| Y N Artificial Bones / Joints  | Y N HIV+ / AIDS               |
| Y N Artificial Valves          | Y N Kidney / Liver Problems   |
| Y N Asthma                     | Y N Lupus                     |
| Y N Cancer                     | Y N Rheumatic / Scarlet Fever |
| Y N Congenital Heart Defect    | Y N Tuberculosis (TB)         |

Please discuss any medical problems that your child has had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



### Has your child ever experienced any of the following?

- |                                |                             |
|--------------------------------|-----------------------------|
| Y N Clenching / Grinding Teeth | Y N Nursing / Bottle Habits |
| Y N Lip Sucking / Biting       | Y N Speech Problems         |
| Y N Mouth Breather             | Y N Thumb / Finger Sucking  |
| Y N Nail Biting                | Y N Tongue Thrust           |

#### Neighbor or Relative not living with you

Name \_\_\_\_\_ Ph # (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_



I understand that the information that I have given is correct to the best of my knowledge, that 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 that my child may need.

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN      DATE

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN      DATE

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN      DATE

**The Parent or Guardian who accompanies the child is responsible for payment.**

**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.**

### OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

**Doctor's Comments:** \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

#### MEDICAL HISTORY UPDATE

I have read my history dated \_\_\_\_\_ and confirmed that it states past and present conditions. \_\_\_\_\_

SIGNATURE      DATE

I have read my history dated \_\_\_\_\_ and confirmed that it states past and present conditions. \_\_\_\_\_

SIGNATURE      DATE