WELCOME

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 lasts a lifetime.

1 Tell Us About Your Child

Today's Date____________

Child's Name:____

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

Nickname:_________________ G Male G Female

School:_________________________________Grade:____

Child's Home #:(___)___________ SS #:_______________

Child's Home Address:_____________________________ Apt./Condo #

____

City State Zip

Email Address:______________________________________

2 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: G Single G Widowed G Partnered G Married G Divorced G Separated

3 Parent's Information

G Mother G Step Mother G Guardian

Name: ______________________ Birthdate: ___/____/___

Wk #: (____)__________Ext.___Hm #: (____)__________

Employer:____

SS#_______________________ DL#__________________

G Father G Step Father G Guardian

Name: ______________________ Birthdate: ___/____/___

Wk #: (____)__________Ext.___Hm #: (____)__________

Employer:____

SS#_______________________ DL#__________________

Neighbor or Relative not living with you:

Name:______________________ Phone#(____)_________

Address:____

____

City State Zip

4 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 #:_______________

5 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? G Yes G No

6 Secondary 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? G Yes G No

7 Why did you bring the child to the dentist today?_______________________________________
____
____

How the child ever had a serious/difficult dental program associated with previous dental work? G Yes G No
Is the child's water fluoridated? G Yes G No
Is the child taking fluoridated supplements? G Yes G No
Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? G Yes G No
Does the child brush his/her teeth daily? G Yes G No
Child's Physician:_________________________________
Phone #:_______________ Date of last visit:___________
Is the child currently under the care of a physician? G Yes G No
Please describe the child's current physical health:
G Good G Fair G Poor
Has the child ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? G Yes G 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 G Yes G No *Metals/Nickel* G Yes G No *Plastic* G Yes G No

8 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? G Yes G No
Anything you would like to discuss with the doctor in private? G Yes G No
Please discuss any serious medical problems that the child has had:__________________________________
____

Does /did the child have any of the following habits?
Y N Sucking/Biting Y N Nursing Bottle Habits
Y N Nail Biting Y N Thumb/Finger Sucking
Was the child breast fed? G Yes G No

Our office is HIPPA 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 medication 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 payment 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 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.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical/dental information above with the parent/ guardian and patient named herein: Initials:__________
Date:____________

Doctor's Comments:
____
____
____
____

Medical History Update

1. Date: _______________ Signature: ________________________________
Comments:
____
____

2. Date: _______________ Signature: ________________________________
Comments:
____
____