

Today's Date: _____

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.

1 TELL US ABOUT YOUR CHILD

Child's Name: _____
Last First Middle
 Goes by: _____ ☐ Male ☐ Female
 Siblings that we treat: _____
 Child's Birthdate: ____/____/____ Child's Age: ____
 School: _____
 Child's Home #: (____) _____
 Child's Home Address: _____

City State Zip

2 MOTHER'S INFORMATION

Name: _____
 Mother Stepmother Guardian Birthdate: ____/____/____
 Address: _____

City State Zip
 Employer: _____
 Work #: (____) _____
 Home #: (____) _____
 Cell #: (____) _____
 SSN: _____ DL#: _____
 Email Address: _____

3 FATHER'S INFORMATION

Name: _____
 Father Stepfather Guardian Birthdate: ____/____/____
 Address: _____

City State Zip
 Employer: _____
 Work #: (____) _____
 Home #: (____) _____
 Cell #: (____) _____
 SSN: _____ DL#: _____
 Email Address: _____

4 WHO MAY WE THANK FOR REFERRING YOU?

5 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____
 Relationship: _____
 Do you have legal custody of this child? ☐ YES ☐ NO

6 PERSON RESPONSIBLE FOR ACCOUNT

Name: _____
 Relationship: _____
 Billing Address: _____

City State Zip
 Work #: (____) _____
 Home #: (____) _____
 Cell #: (____) _____
 Email Address: _____

7 PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____
 Insurance Co. Address: _____

City State Zip
 Insurance Phone #: (____) _____
 Group # (Plan, Local, or Policy #): _____
 Policy Owner's Name: _____
 Relationship to Patient: _____
 Policy Owner's Birthdate: ____/____/____
 SSN: _____
 Policy Owner's Employer: _____

8 SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____
 Insurance Co. Address: _____

City State Zip
 Insurance Phone #: (____) _____
 Group # (Plan, Local, or Policy #): _____
 Policy Owner's Name: _____
 Relationship to Patient: _____
 Policy Owner's Birthdate: ____/____/____
 SSN: _____
 Policy Owner's Employer: _____

9 DENTAL HISTORY

Child's Name _____

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous dentist's name: _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain: _____

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

Does the child have any of the following habits?

☐ ☐ Lip Sucking / Biting ☐ ☐ Nail Biting

☐ ☐ Nursing / Bottle Habits ☐ ☐ Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? ☐ ☐

If yes, please explain: _____

Is the child's water fluoridated? ☐ ☐

Is the child taking fluoride supplements? ☐ ☐

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? ☐ ☐

Does the child brush his/her teeth daily? ☐ ☐

Floss his/her teeth daily? ☐ ☐

11. I understand that the information 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

Relationship to Patient

FOR OFFICE USE ONLY

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

Initials _____ Date _____

Has the child ever had any of the following conditions?

<input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> <input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> <input type="checkbox"/> Allergies to any Drugs	<input type="checkbox"/> <input type="checkbox"/> Handicaps/Disabilities
<input type="checkbox"/> <input type="checkbox"/> Allergies to Food	<input type="checkbox"/> <input type="checkbox"/> Hearing Impairment
<input type="checkbox"/> <input type="checkbox"/> Allergies to Food Dyes	<input type="checkbox"/> <input type="checkbox"/> Heart Disease/Murmur
<input type="checkbox"/> <input type="checkbox"/> Any Hospital Stays	<input type="checkbox"/> <input type="checkbox"/> Hepatitis
<input type="checkbox"/> <input type="checkbox"/> Any Operations	<input type="checkbox"/> <input type="checkbox"/> HIV + / AIDS
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Kidney/Liver Conditions
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Rheumatic/Scarlet Fever
<input type="checkbox"/> <input type="checkbox"/> Congenital Birth Defects	<input type="checkbox"/> <input type="checkbox"/> Allergies to Latex Product
<input type="checkbox"/> <input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Pregnancy	<input type="checkbox"/> <input type="checkbox"/> Hemophilia/Blood Disorders
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Reflux/GI Problems

Please discuss any serious medical conditions the child has had:

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

Please list all drugs the child is allergic to: _____

Child's Physician: _____

Phone #: (_____) _____

Is the child currently under the care of a physician? ☐ ☐

Please describe the child's current physical health:

☐ ☐ ☐

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