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: _____

Nickname: _____ Birthdate: _____ Age: ____

❑ Male ❑ Female School : _____

Child's Home Address: _____

City, State & Zip Code: _____

Child's Home # : ( ) _____

2 Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑Y ❑ N

Whom may we thank for referring you? _____

Other family members seen by us: _____

_____

Previous/Present Dentist: _____

Last Visit: _____ Last Cleaning: _____

3 Mother's Information: ❑Stepmother ❑Guardian

Name: _____ Birthdate: _____

Hm#( ) _____ Wk#( ) _____ Cell _____

Employer: _____

SS#: _____ DL#: _____

E-Mail _____

Father's Information : ❑Stepfather ❑Guardian

Name: _____ Birthdate: _____

Hm#( ) _____ Wk#( ) _____ Cell _____

Employer: _____

SS#: _____ DL#: _____

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

4 Person Responsible For Account:

Name: _____ Relation: _____

Billing Address: _____

_____

How long at this address? _____ Hm# _____

Previous Address (if less than 3 yrs.) _____

_____

Employer: _____

Occupation _____ #Yrs Employed ___

Wk#( ) _____ Ext. ____ DL# _____

SS# _____ Birthdate: _____

Spouse's Name _____ Birthdate: _____

Employer: _____

Occupation: _____ #Yrs Employed _____

Wk#( ) _____ Ext: ___ SS# _____

5 Dental Insurance:

Policy Owner's Name: _____

Ins. Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone # : ( ) _____

Group #: _____ SS#: _____

Relation to patient: _____ Birthdate: _____

Employer: _____

Do you have Secondary Coverage? ❑ Yes ❑ No

Policy Owner's Name: _____

Employer: _____

Ins. Co. Name: _____

Ins. Co. Phone # : ( ) _____

Group #: _____ SS#: _____

OVER PLEASE

6 Dental History:

Why did 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 ? Or is the child taking fluoridated supplements ?	❑ Yes	❑ No
Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD) ?	❑ Yes	❑ No
Does the child brush his / her teeth daily ? ❑ Yes ❑ No Floss his / her teeth daily?	❑ Yes	❑ No
Does / did the child have any of the following habits? Lip sucking/biting	❑ Yes	❑ No
Nursing Bottle Habits	❑ Yes	❑ No
Nail Biting	❑ Yes	❑ No
Thumb / Finger Sucking	❑ Yes	❑ No

Previous / Present Dentist : _____ Last visit date: _____

Last cleaning appt. : _____

7 Medical History :

Has the child had any of the following medical problems ?

Abnormal Bleeding	Yes❑	No❑	Handicaps / Disabilities	Yes❑	No❑
Allergies to any drugs	Yes❑	No❑	Hearing Impairment	Yes❑	No❑
Any Hospital Stays	Yes❑	No❑	Heart Murmur	Yes❑	No❑
Any Operations	Yes❑	No❑	Hemophilia	Yes❑	No❑
Asthma	Yes❑	No❑	Hepatitis	Yes❑	No❑
Cancer	Yes❑	No❑	HIV+ / AIDS	Yes❑	No❑
Congenital Heart Defect	Yes❑	No❑	Kidney / Liver Problems	Yes❑	No❑
Convulsions / Epilepsy	Yes❑	No❑	Rheumatic / Scarlet Fever	Yes❑	No❑
Diabetes	Yes❑	No❑	Tuberculosis (TB)	Yes❑	No❑

Child's Physician : _____ Phone : _____

Is the child currently under the care of a physician ? ❑ Yes ❑ No Date of Last Visit: _____

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

_____

Please list all drugs that the child is allergic to : _____

_____

Please discuss any serious medical problems that the child has had : _____

_____

_____

8

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 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. I understand that where appropriate, credit bureau reports may be obtained.

Signature of parent or guardian: _____ Date: _____