



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 # : () _____

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# _____

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: _____
 Wk#() _____ Cell#() _____
 Hm#() _____
 Employer: _____
 SS#: _____ DL#: _____
Father's Information : Stepfather Guardian
 Name: _____ Birthdate: _____
 Wk#() _____ Cell#() _____
 Hm#() _____
 Employer: _____
 SS#: _____ DL#: _____
Parent's Marital Status: Single Widowed

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 : _____

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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: _____