

About Your Child

Name: _____
Last

_____ Middle Initial

First

Nickname: _____ Male Female

Birth date: ____/____/____

School: _____

Address: _____
Street

_____ City State ZIP

Home Phone: (____) _____

Other family seen by us: _____

Previous Dentist: _____

Last Visit Date: _____

Parent (Guardian) Information

Who is accompanying the child today (name & relationship)?

If it were an option, would you prefer to receive appointment reminders by email? Yes No

Mother

Name: _____

Birth date: ____/____/____ SS#: _____

Home: (____) _____ Cell: (____) _____

Work: (____) _____ Email: _____

Father

Name: _____

Birth date: ____/____/____ SS#: _____

Home: (____) _____ Cell: (____) _____

Work: (____) _____ Email: _____

Person Responsible for Account

Who is responsible for the child's account?

Who is responsible for making the child's appointments?

Dental Information

Reason for today's visit _____

Please explain briefly if you have questions or concerns about your child's dental conditions (e.g. orthodontic treatments)

Is the child currently in pain? Yes No

Has the child ever had a serious problem associated with any previous dental work? Yes No

Has the child experienced any of the following in his/her jaw joints?

Clicking Yes No

Pain (jaw joint, ear, neck) Yes No

Difficulty in opening or closing Yes No

Difficulty chewing Yes No

Does the child clench or grind his/her teeth? Yes No

Has the child had any orthodontic treatment? Yes No

What kind of water does the child usually drink?
 City Water Well Water Bottled Water Other

Does the child take fluoridated supplements? ... Yes No

Do the child's gums bleed in brushing/flossing? Yes No

Does the child brush his or her own teeth? Yes No

How many times a **week** does the child floss? ____/week

How many times a **day** does the child brush? ____/day

Please let us know if there is someone we can thank for referring you.

Continued on back...

Health Information

Please describe your child's current physical health:

Good Fair Poor

Does the child need to take antibiotics before dental appointments? Yes No

Is the child currently undergoing any treatment? Yes No

If so, please explain: _____

Please list any prescription medications your child is taking:

Be sure to list any blood thinners (i.e. Coumadin, Warfarin) and biphosphonates (i.e. Fosamax, Actonel, Boniva) for osteoporosis.

Medical History

Please mark if your child has ever had any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Artificial Joints/ Valves | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV+/AIDS |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Hospitalized for Any Reason |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Hearing Impairments | <input type="checkbox"/> Transplant |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tuberculosis (TB) |

None of the above applies

Are your child's immunizations current? Yes No

Does/did your child have any of the following habits?

Lip Sucking/Biting Yes No

Nail Biting Yes No

Nursing Bottle Habits Yes No

Thumb/Finger Sucking Yes No

Was the child breast-fed? Yes No

Allergies

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Erythromycin | |

None of the above applies

Please list any other drugs your child is allergic to:

Dental Insurance-----Please fill completely

I do not have dental insurance

Primary Dental Insurance

Insurance Co. Name: _____

Group Number: _____

Subscriber's Name: _____

Subscriber's Birth Date: ____/____/____

Subscriber's SS#: _____

ID# (if different from SS#) _____

Subscriber's Employer _____

Relationship to Patient: _____

I do not have secondary dental insurance

Secondary Dental Insurance (if applicable)

Insurance Co. Name: _____

Group Number: _____

Subscriber's Name: _____

Subscriber's Birth Date: ____/____/____

Subscriber's SS#: _____

ID# (if different from SS#) _____

Subscriber's Employer _____

Relationship to Patient: _____

Payment is due in full at the time of treatment unless prior arrangements have been made. Insurance co-pays are due within 30 days of the billing date. Since we set aside time specifically for you, please note that there is a \$75 fee for breaking an appointment without contacting us or cancelling

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

I authorize my insurance company to pay the benefits otherwise payable to me.

I understand that I am responsible for payment of services rendered and also responsible for paying any portion of my treatment fees that my insurance does not cover. I also understand that any fees for overdue payments, broken appointments, and cancellation with less than 24-business-hour notice will be my responsibility.

X _____
Signature of a parent or guardian

____/____/____
Date