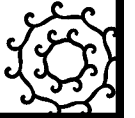




WELCOME!



ALL about your CHILD

Child's Name: _____ Birth date: ___/___/___
 Age: _____ Nickname: _____ Male ___ Female ___
 Home Phone #: (____) _____ Address: _____
 City: _____ State: _____ Zip: _____
 Favorite Hobbies: _____

PARENT'S INFORMATION

Parent's Marital Status: __married__ __divorced__ __separated__ __widowed__ __remarried__ __single__ __partnered__

Mother: Name : _____ Birth date: ___/___/___

Social security #: _____ Driver's License #: _____

Address: _____ City : _____ State: _____ Zip: _____

Home Phone #; (____) _____ Cell #: (____) _____ Work #:(____) _____

E-mail Address: _____

Employer: _____ Length of Employment: _____

Father: Name : _____ Birth date: ___/___/___

Social security #: _____ Driver's License #: _____

Address: _____ City : _____ State: _____ Zip: _____

Home Phone #; (____) _____ Cell #: (____) _____ Work #:(____) _____

E-mail Address: _____

Employer: _____ Length of Employment: _____

INSURANCE

Primary Insurance:

Insurance Co. Name: _____ Phone #: (____) _____

Group/Policy # : _____ Insurance Co. Address: _____

_____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Relation to patient: _____

Insured's Birthdate: ___/___/___ Insured's ID#: _____ Insured's Employer: _____

Secondary Insurance:

Insurance Co. Name: _____ Phone #: (____) _____

Group/Policy # : _____ Insurance Co. Address: _____

_____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Relation to patient: _____

Insured's Birthdate: ___/___/___ Insured's ID#: _____ Insured's Employer: _____



Dental History



Is your child currently in pain? yes no

What is the primary reason for today's visit? _____

Has your child experienced problems with previous dental work? yes no

Does your child brush his/her teeth daily? yes no How many times a day? _____

Floss his/her teeth daily? yes no

Previous / present Dentist : _____ Date of last visit: / /

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

- | | | | |
|--------------------------|--------------------------------|---------------------------|---------------------|
| Y N Lip sucking / biting | Y N Clenching / grinding teeth | Y N Tongue / Cheek biting | Y N Mouth breather |
| Y N Nail biting | Y N Thumb / finger Sucking | Y N Used pacifier | Y N Speech problems |
| Y N Chewing on objects | Y N Nursing bottle habits | Y N Tongue thrust | Y N Breast fed |

Medical History

Child's Physician: _____ Phone #: (____) _____ Date of last visit: _____

Address: _____ City: _____ State: _____ Zip: _____

Is your child currently under the care of their physician? _____ If yes, please explain: _____

Please indicate your child's current health: good fair poor Are immunizations current? _____

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

Besides the following, please list all drugs and/or things that cause your child allergic reactions:

Y N latex Y N metals/nickel Y N plastic Y N penicillin/amoxicillin Y N tetracycline

Other : _____

Anything you would like to discuss with the Doctor in private? _____

Does / did your child experience any of the following?

- | | | | |
|----------------------------------|------------------------------|----------------------------|------------------------|
| Y N Abnormal bleeding | Y N Congenital heart defect | Y N High blood pressure | Y N Rheumatic fever |
| Y N AIDS /HIV+ | Y N Convulsions | Y N Hives | Y N Scarlet fever |
| Y N Allergies | Y N Diabetes | Y N Kidney problems | Y N Sickle cell anemia |
| Y N Anemia | Y N Epilepsy | Y N Liver problems | Y N Skin Rash |
| Y N Any hospital stay/operations | Y N Handicaps / disabilities | Y N Low blood pressure | Y N Tonsillitis |
| Y N Asthma | Y N Hearing impairment | Y N Lupus | Y N Tuberculosis (TB) |
| Y N Blood transfusion | Y N Heart murmur | Y N Measles | |
| Y N Cancer | Y N Hemophilia | Y N Mitral valve prolapsed | |
| Y N Chicken pox | Y N Hepatitis | Y N Mononucleosis | |

Please discuss any serious medical problems your child experiences/ed: _____

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that 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 services that my child may need. I assign the Doctor all insurance benefits.

I understand that any estimated co-payments are due at the time services are rendered and that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature of parent or guardian: _____ Date: / /