

# Welcome!

## Tell Us About Your Child

Today's Date: \_\_\_\_\_ Child's Home Phone #: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Child's Name: \_\_\_\_\_ Child's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age: \_\_\_\_\_  
Nickname: \_\_\_\_\_ Last First MI  Male  Female School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Child's Home Address: \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Email Address: \_\_\_\_\_

## Parent's Information

Parent's Marital Status:  Married  Divorced  Separated  Widowed  Remarried  Single  Partnered

**Mother** Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_  
Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Employer: \_\_\_\_\_ Street City State Zip Length of Employment: \_\_\_\_\_  
**Father** Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_  
Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Employer: \_\_\_\_\_ Street City State Zip Length of Employment: \_\_\_\_\_

## Insurance Information

**Primary Insurance** Dental Coverage?  Yes  No Orthodontic Coverage?  Yes  No Medical Coverage?  Yes  No  
Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local, or Policy #): \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ PO Box/Street City State Zip Relationship to Patient: \_\_\_\_\_  
Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's ID #: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
**Secondary Insurance** Dental Coverage?  Yes  No Orthodontic Coverage?  Yes  No Medical Coverage?  Yes  No  
Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local, or Policy #): \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ PO Box/Street City State Zip Relationship to Patient: \_\_\_\_\_  
Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's ID #: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Street City State Zip

CONTINUED ON BACK

## Dental History

Is the child currently in pain?  Yes  No What is the primary reason for today's visit? \_\_\_\_\_

Has the child experienced problems with previous dental work?  Yes  No

Does the child brush his / her teeth daily?  Yes  No

Floss his / her teeth daily?  Yes  No

Previous / Present Dentist: \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
(Please Circle)

Why did you leave your previous dentist? \_\_\_\_\_

What did you like most about any dentist you have seen? \_\_\_\_\_ Least? \_\_\_\_\_

Does / did the 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: \_\_\_\_\_  
Street City State Zip

Is the child currently under the care of a physician?  Yes  No Please explain: \_\_\_\_\_

Please describe the child's current physical health:  Good  Fair  Poor Are Immunizations Current?  Yes  No

Please list all drugs that the child is currently taking: \_\_\_\_\_

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

Latex?  Yes  No Metals/Nickel  Yes  No Plastic?  Yes  No Penicillin?  Yes  No Tetracycline?  Yes  No

Anything you would like to discuss with the Doctor in private?  Yes  No

Does/did the 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 Prolapse

Y N Chicken Pox Y N Hepatitis Y N Mononucleosis

Please discuss any serious medical problems the 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 I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature \_\_\_\_\_

Date \_\_\_\_\_