Tell Us About Your Child

Today's Date: _____ Child's Home Phone #: (___)_____ Social Security #:_____

Child's Name:_____ Child's Birthdate: __/__/_____ Child's Age:_____

Nickname:_____ ❑ Male ❑ Female School: _____ Grade:_____

Child's Home Address:_____
Street City State Zip

Who Is Accompanying The Child Today!

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No Is the child adopted? ❑ Yes ❑ No

Is the child in a foster home? ❑ Yes ❑ No

Whom may we thank for referring you?_____ Other siblings seen by us:_____

Neighbor or Relative not living with you

His/Her Name:_____ Relation:_____ Wk Phone #:_____ Hm Phone #: _____

Address: _____
Street City State Zip

Parent's Information

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

Mother: ❑ Step Mother ❑ Guardian Birthdate: __/__/____ Hm Ph #: (___)_____ Wk Ph #: (___)_____

Name: _____ SSN: _____ Driver's License #: _____

Address: _____
Street City State Zip

Employer: _____ Length of Employment _____

Father: ❑ Step Father ❑ Guardian Birthdate: __/__/____ Hm Ph #: (___)_____ Wk Ph #: (___)_____

Name: _____ SSN: _____ Driver's License #: _____

Address: _____
Street City State Zip

Employer: _____ Length of Employment _____

Person Responsible for Account

Name: _____ Relationship:_____ SSN: _____

Billing Address: _____
Street City State Zip

Wk Ph: (___)_____ Hm Ph: (___)_____ Employer: _____ Dvr's Lic.:_____

Who is responsible for making appointment?

Name: _____ Wk Ph: (___)_____ Hm Ph: (___)_____ Best time to call: _____

Insurance Information

Medical Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No Orthodontic Coverage: ❑ Yes ❑ No

Insurance Co. Name _____ Ph: (___)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street City State Zip

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate:__/__/____ SSN: _____ Policy Owner's Employer: _____

Employer's Address: _____
Street City State Zip

Medical Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No Orthodontic Coverage: ❑ Yes ❑ No

Insurance Co. Name _____ Ph: (___)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street City State Zip

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate:__/__/____ SSN: _____ Policy Owner'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 ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ❑ Yes ❑ No

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

Is the child's water fluoridated? ❑ Yes ❑ No

Is the child taking fluoridated supplement? ❑ Yes ❑ No

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

Floss his / her teeth daily? ❑ Yes ❑ No

Previous / Present Dentist: (circle one)_____ Date of Last Visit:_____

Why did you leave your previous dentist:_____

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

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

Y N Breast Fed	Y N Mouth Breather	Y N Thumb / Finger Sucking
Y N Chewing on Objects	Y N Nail Biting	Y N Tongue / Cheek Biting
Y N Clenching / Grinding Teeth	Y N Nursing Bottle Habits	Y N Tongue Thrust
Y N Lip Sucking / Biting	Y N Speech Problems	Y N Used Pacifier

Medical History

Child's Physician:_____ Ph:(___)_____ 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 **Pregnant** ❑ Yes ❑ No **How many months**_____

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

Please list all drugs and/or other things that cause the child allergic reactions:_____

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

Has the child had/experienced any of the following:

Y N Abnormal Bleeding	Y N Diabetes	Y N Lupus
Y N AIDS / HIV+	Y N Epilepsy	Y N Measles
Y N Allergies to_____	Y N Handicaps / Disabilities	Y N Mitral Valve Prolapse
Y N Anemia	Y N Hearing Impairment	Y N Mononucleosis
Y N Any Hospital Stays / Operations	Y N Heart Murmur	Y N Psychiatric Disorder / Care
Specify_____	Y N Hemophilia	Y N Rheumatic Feaver
Y N Blood Transfusion	Y N Hepatitis Type_____	Y N Scarlet Fever
Y N Cancer	Y N Hives	Y N Sickle Cell Anemia / Trait
Y N Chicken Pox / Innoculation	Y N Kidney Problems	Y N Skin Rash
Y N Congenital Heart Defect	Y N Liver Problems	Y N Tonsillitis
Y N Convulsions / Seizures	Y N Low or High Blood Pressure	Y N Tuberculosis (TB)
Type_____ Last Time_____		Y N Asthma

Please discuss any serious medical problems the child experienced/ed:_____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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. My method of payment will be_____.

_____
Signature of parent of guardian Date

I certify that my child is covered by _____Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of parent of guardian Date

The parent or guardian who accompanies the child is responsible for payment at time of service