WELCOME!

TELL US ABOUT YOUR CHILD

Today's Date: _____

We sincerely welcome you and your child into our practice. We will make your dental visits as pleasant as we can. In order for us to better understand your child; please complete this form as thoroughly as possible. Thank you.

Child's name: _____ Nickname: _____

Child's Birthdate: ____/____/____ Child's Age: _____ O Male O Female Weight: _____

School: _____ Grade: _____ Social Security #: _____

Child's Home Address: _____

Street City State Zip

Name of Siblings: _____

Name of child's favorite (pet, toy, friend, etc.) _____

Whom may we thank for referring you? _____

What is your main concern for your visit today? _____

_____

PARENT'S INFORMATION

Parents Marital Status: O Married O Divorced O Separated O Remarried O Single

Mother: Birthdate: ____/____/____ Name: _____ Social Security #: _____

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

Address: _____ Drivers License #: _____

Street City State Zip

Employer: _____ Email Address: _____

Father: Birthdate: ____/____/____ Name: _____ Social Security #: _____

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

Address: _____ Drivers License #: _____

Street City State Zip

Employer: _____ Email Address: _____

Who is the child's legal guardian?: _____

INSURANCE INFORMATION

Dental Insurance:

Insurance Company Name: _____ Phone #: ( )_____ Group #: _____

Insurance Company Address: _____

PO Box/Street City State Zip

Insured's Name: _____ Member ID: _____

Insured's Birthdate: ____/____/____ Social Security #: _____ Insured Employer: _____

Employer's Address: _____

Street City State Zip

Is there orthodontic coverage?: O Yes O No

DENTAL HISTORY

Is the child currently in pain? O Yes O No If yes, where does it hurt? _____
Has the child experienced problems with previous dental work? O Yes O No
Does the child brush his/her teeth daily? O Yes O No
Floss his/her teeth daily? O Yes O No
Previous/Present Dentist: _____ Date of Last Visit: _____

Does your child have any of the following habits?

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

MEDICAL HISTORY

Child's Physician: _____ Phone #: ( )_____ Date of Last Visit: _____
Is the child currently under the care of a physician? O Yes O No If yes, please explain why? _____
Please describe the child's current physical health: O Good O Fair O Poor **Are Immunizations Current?** O Yes O No
Please list all drugs the child is currently taking: _____
Please list all drugs and or things that cause the child allergic reactions: _____
Is there anything you would like to discuss with the doctor in private? O Yes O No

Has the child had/experienced any of the following:

O Abnormal Bleeding	O Congenital Heart Defect	O High Blood Pressure	O Rheumatic Fever
O AIDS/HIV+	O Convulsions	O Hives	O Scarlet Fever
O Allergies	O Diabetes	O Kidney Problems	O Sickle Cell Anemia
O Anemia	O Epilepsy	O Liver Problems	O Skin Rash
O Any Hospital Stay/Operations	O Handicaps/Disabilities	O Low Blood Pressure	O Tonsillitis
O Asthma	O Hearing Impairment	O Lupus	O Tuberculosis (TB)
O Blood Transfusion	O Heart Murmur	O Measles	
O Cancer	O Hemophilia	O Mitral Valve Prolapse	
O Chicken Pox	O Hepatitis	O Mononucleosis	

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

NOTICE OF PRIVACY PRACTICES:
OUR OFFICE COMPLIES WITH HIPPA. YOU MAY HAVE A COPY OF THE NOTICE OF PRIVACY PRACTICE THAT IS POSTED IN THE OFFICE.
PLEASE CIRCLE: I WANT A COPY / I DO NOT WANT A COPY SIGNATURE _____ AAKD_____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

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 THE 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.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

THE PARENT OR GUARDIAN WHO ACCOMPANIES THE CHILD IS RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY
I VERBALLY REVIEWED THE MEDICAL/DENTAL INFORMATION ABOVE WITH THE PARENT/GUARDIAN AND PATIENT NAMED HEREIN.
INITIALS_____ DATE _____