



# Welcome

## Tell Us About Your Child

Today's Date: \_\_\_\_\_ Child's Home Phone #: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Child's Name: \_\_\_\_\_ Child's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age: \_\_\_\_\_  
Last First MI  
 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: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street City State Zip

## Parent's Information

Parent's Marital Status:  Married  Divorced  Separated  Widowed  Remarried  Single  
**Mother:**  Step Mother  Guardian Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_  
 Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street City State Zip  
 Employer: \_\_\_\_\_ Length of Employment: \_\_\_\_\_

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

## Person Responsible for Account

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Billing Address: \_\_\_\_\_  
Street City State Zip  
 Work Phone #: (\_\_\_\_) \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ Employer: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

### Who is responsible for making appointments?

Name: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ Best time to call: \_\_\_\_\_

## Insurance Information

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

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



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 supplements?  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 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        |

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: \_\_\_\_\_

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

**Please discuss any serious medical problems the child experiences/ed:** \_\_\_\_\_

Medical History

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 or 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 services 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 or guardian

\_\_\_\_\_  
Date

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