WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help your child reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for your family.

ABOUT YOUR CHILD

Today's Date_____ E-Mail Address_____

Name:_____

I prefer to be called:_____

Male____ Female____

Birthdate_____SSN_____

Home Address:_____

_____

Home Phone_____

Other family members seen by us_____

_____

Parent Information

Mother's Name_____

Birth Date_____SSN_____

Cell Phone_____

Mother's Employer_____

Work Number_____Ext._____

☺☺☺☺☺☺☺☺☺☺☺☺☺☺☺☺☺☺☺☺

Father's Name_____

Cell Phone_____

Birth Date_____SSN_____

Father's Employer_____

Work Number _____Ext._____

Billing Address if different from child's address_____

_____

_____

INSURANCE

Medical Coverage Yes No
Dental Coverage Yes No

Insurance Co. Name_____

Insurance Co. Address_____

_____

Insurance Co. Phone #_____

Group # (Plan, Local, or Policy #)_____

Insured's Name_____

Relationship_____

Insured's Birthdate___/___/___

Insured's SSN _____

Insured's Employer_____

Employer's address_____

_____

SECONDARY INSURANCE

Medical Coverage Yes No Dental Coverage Yes No

Insurance Co. Name_____

Insurance Co. Address_____

_____

Insurance Co. Phone #_____

Group # (Plan, Local, or Policy #)_____

Insured's Name_____

Relationship_____

Insured's Birthdate___/___/___ Insured's SSN _____

Insured's Employer_____

Employer's address_____

MEDICAL HISTORY

Child's physical health is ____Good ___Fair ___Poor

Does he/she have a personal physician? yes_____ No_____

Is child currently under the care of a physician? _____

Please explain_____

Has child had any pins, rods, or implants?_____

Is child taking any prescription / over-the-counter drugs?

Please list each one:_____

_____

Has child ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Hepatitis A B C
Y N Alcohol / Drug Abuse	Y N Herpes/Fever Blisters
Y N Anemia	Y N High Blood Pressure
Y N Arthritis	Y N HIV+ / AIDS
Y N Artificial bones/joints/valves	
Y N Asthma	Y N Kidney Problems
Y N Blood Transfusion	Y N Liver Disease
Y N Cancer / Chemotherapy	Y N Low Blood Pressure
Y N Colitis	Y N Mitral Valve Prolapse
Y N Congenital Heart Disease	Y N Pacemaker
Y N Diabetes	Y N Psychiatric Problems
Y N Difficulty Breathing	Y N Radiation Treatment
Y N Emphysema	Y N Rheumatic Fever
	Y N Scarlet Fever
Y N Epilepsy	Y N Seizures
Y N Fainting Spells	Y N Shingles
Y N Frequent Headaches	Y N Sickle Cell Disease
Y N Glaucoma	Y N Sinus Problems
Y N Hay Fever	Y N Stroke
Y N Heart Attack	Y N Thyroid Problems
Y N Heart Murmur	Y N Tuberculosis (TB)
Y N Heart Surgery	Y N Ulcers
Y N Hemophilia	

Has child ever been hospitalized for any reason?_____

_____

Is child allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other
Y N Dental Anesthetics		Y N Penicillin

Please list any other drugs/materials that child is allergic to:

_____

DENTAL HISTORY

Why has child come to the dentist today?_____

_____

Does child require antibiotics before dental treatment? _____

Is child currently in pain? _____

Has child ever had a serious / difficult problem associated with any previous dental work? _____Yes _____No

Has child ever experienced pain / discomfort in his/her jaw joint (TMJ / TMD)?_____

Child's current dental health is _____Good ____Fair __Poor

Do you like your child's smile? ___Y ___N

Do your child's gums ever bleed? ___Y ___N

How many times a week does your child floss? _____

How many times a day does your child brush? _____

Type of bristles ____Soft ____ Medium ____ Hard

How long does your child use a toothbrush before replacing it?
_____

Are your child's teeth sensitive to heat, cold, or anything else?_____

Has your child lost any teeth? ____No ____Yes. If so, why?_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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.

X_____
Parent's Signature Date

Payment is due in full at the time of treatment

.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

X_____
Parent's Signature Date