WELCOME!

ALL about your child

Child's Name: _____ Birth date: ____/____/____
Age: _____ Nickname: _____ Male ___ Female ___
Home Phone #: (___)_____ Address: _____
City: _____ State: _____ Zip: _____
Favorite Hobbies: _____

Parent's Information

Parent's Marital Status: __married __divorced __separated __widowed __remarried __single __ partnered
Mother: Name : _____ Birth date: ___/___/____
Social security #: _____ Driver's License #: _____
Address: _____ City : _____ State: _____ Zip: _____
Home Phone #; (___)_____Cell #: (___)_____ Work #:(___)_____
E-mail Address: _____
Employer: _____ Length of Employment: _____
Father: Name : _____ Birth date: ___/___/____
Social security #: _____ Driver's License #: _____
Address: _____ City : _____ State: _____ Zip: _____
Home Phone #; (___)_____Cell #: (___)_____ Work #:(___)_____
E-mail Address: _____
Employer: _____ Length of Employment: _____

Insurance

Primary Insurance:
Insurance Co. Name: _____ Phone #: (___)_____
Group/Policy # : _____ Insurance Co. Address: _____
_____ City:_____ State: _____ Zip: _____
Insured's Name: _____Relation to patient: _____
Insured's Birthdate: ___/___/_____ Insured's ID#: _____Insured's Employer:_____
Secondary Insurance:
Insurance Co. Name: _____ Phone #: (___)_____
Group/Policy # : _____ Insurance Co. Address: _____
_____ City:_____ State: _____ Zip: _____
Insured's Name: _____Relation to patient: _____
Insured's Birthdate: ___/___/_____ Insured's ID#: _____Insured's Employer:_____

Dental History

Is your child currently in pain? __yes __no
What is the primary reason for today's visit? _____
Has your child experienced problems with previous dental work? __yes __no
Does your child brush his/her teeth daily? __yes __no How many times a day? _____
Floss his/her teeth daily? __yes __no
Previous / present Dentist : _____Date of last visit: ___/___/_____

Does / did your 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: _____City: _____State: _____Zip: _____
Is your child currently under the care of their physician? _____ If yes, please explain: _____
Please indicate your child's current health: ___good ___fair ___poor Are immunizations current? _____
Please list all drugs that your child is currently taking: _____
Besides the following, please list all drugs and/or things that cause your child allergic reactions:
Y N latex Y N metals/nickel Y N plastic Y N penicillin/amoxicillin Y N tetracycline
Other : _____
Anything you would like to discuss with the Doctor in private? _____
Does / did your 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 prolapsed	
Y N Chicken pox	Y N Hepatitis	Y N Mononucleosis	

Please discuss any serious medical problems your 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 any estimated co-payments are due at the time services are rendered and that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.
Signature of parent or guardian: _____Date:____/____/_____