FOR CHILDREN: WELCOME TO OUR PRACTICE

1.) TELL US ABOUT YOUR CHILD

Date:_____ AGE:_____ DOB:_____

Child's Name:

_____
Last First MI

What does your child like to be called:
_____ ☐ Male ☐ Female

School:_____ Grade: _____

Home #: _____

Child's Home Address:

_____
Apt #

_____
City State Zip

Siblings
Name: _____ Age: _____
Name: _____ Age: _____

EMERGENCY CONTACT
Name: _____
Phone#:_____

2.) HOW DID YOU HEAR ABOUT US ?

RECOMMENDED BY (CIRCLE):

Dentist Family Friend

Phone Book Internet Drive By

OTHER:_____

WHO MAY WE THANK FOR REFFERING YOU

_____

OTHER FAMILY MEMBERS SEEN BY US

_____

3.) Who is responsible for making appts?

Name: _____
WK #: _____ Ext._____
HM# : _____ Cell# : _____
Email: _____

4.) PARENT / LEGAL GUARDIAN

MOTHER/ FATHER/ GUARDIAN

Name: _____
WK #: _____ Ext. _____
HM# : _____ Cell# : _____
Employer: _____
DL# : _____
SS# : _____

MOTHER/ FATHER/ GUARDIAN

Name: _____
WK #: _____ Ext. _____
HM# : _____ Cell# : _____
Employer: _____
DL# : _____
SS# : _____
Parent's Marital Status: _____

5.) PRIMARY DENTAL INSURANCE

Ins. Name: _____
Ins Address: _____
Insurance Co. Phone : _____
Group/ Policy # : _____
Insured's Name : _____
Relationship to Patient : _____
Insured's DOB: _____
Insured's Employer: _____
SS# : _____
Orthodontic Coverage: YES NO

SECONDARY DENTAL INSURANCE

Ins. Name: _____
Ins Address: _____
Insurance Co. Phone : _____
Group/ Policy # : _____
Insured's Name : _____
Relationship to Patient : _____
Insured's DOB: _____
Insured's Employer: _____
SS# : _____
Orthodontic Coverage: YES NO

6.) DENTAL QUESTIONS

What are your/ your dentist's concerns for the child/ teen today?

Has the child had pervious orthodontic treatment or appliances?

Has anyone in the immediate family had surgery to the jaws?

Has the child/teen had extensive dental treatment?

Has the child/teen had any trauma to the mouth or face?

Has the child/teen had any pain or tenderness in the jaw joints (TMJ/TMD) ?

How many times a day does the child/teen brush their teeth?

How often does the child/teen floss?

Are there any of the following habits?
(circle those that apply)

Thumb or finger sucking
Lip sucking or biting
Nail biting
Tongue thrusting between the teeth
Other: _____

Current Dentist:_____
Address:_____
Phone Number:_____
Last Appointment:_____

7.) MEDICAL HISTORY QUESTIONS

Has the child/teen had any of the following?

Y N Heart murmur (Antibiotic required)?
Y N Congenital heart defect
Y N Cancer
Y N Diabetes
Y N Convulsions/Epilepsy
Y N Rheumatic/Scarlet Fever
Y N HIV+/AIDS
Y N Hemophilia
Y N Asthma
Y N Hepatitis
Y N Tuberculosis
Y N Artificial joints or limbs
Y N Abnormal bleeding
Y N Hearing impairment
Y N Kidney/liver problems
Y N Pregnant

Major Illness not listed above:

Operations/Hospital Stays:

Current Medication:

Allergies: LATEX METALS IBUPROFEN
Others:_____
_____

Physician:_____
Address:_____
Phone Number:_____
Last appointment:_____

8.) I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes to my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of parent/guardian Date

The parent/guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.