Patient ID # ________________ Today's Date __________

Welcome

to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name ______________________________

Nickname ________________ Sex ________

Birthdate ________________ Age ________

SS# ______________________________

School ________________ Grade ________

Child's Home Address ______________________________

City ________________ State ______ Zip ________

Phone ______________________________

Responsible Party

Name ______________________________

Relationship ______________________________

Address ______________________________

City ________________ State ________ Zip ________

Email ______________________________

SS# ______________________________

DL# ______________________________

Who is responsible for making appointments?

Name ______________________________

Home Phone ____________ Cell Phone ____________

Work Phone ________________ Ext. ________

Best time to call ______________________________

Time ____________ Days ____________

____

Mother

☐ Stepmother ☐ Guardian

Name ______________________________

Home Phone ____________ Cell Phone ____________

Work Phone ________________ Ext. ________

Email ______________________________

Employer ______________________________

Occupation ______________________________

SS# ______________________________

DL # ______________________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father

☐ Stepfather ☐ Guardian

Name ______________________________

Home Phone ____________ Cell Phone ____________

Work Phone ________________ Ext. ________

Email ______________________________

Employer ______________________________

Occupation ______________________________

SS# ______________________________

DL # ______________________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name ______________________________

Relationship ______________________________

Birthdate ____________ SS# ____________

Employer ________________ Date Employed ________

Occupation ______________________________

Insurance Company ______________________________

Group # ________________ Employee # ________

Additional Insurance

Insured's Name ______________________________

Relationship ______________________________

Birthdate ____________ SS# ____________

Employer ________________ Date Employed ________

Occupation ______________________________

Insurance Company ______________________________

Group # ________________ Employee # ________

Dental & Health History *CONFIDENTIAL* Patient ID # ______

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? ______ How often does your child floss? ______

Is your child's water fluoridated? ☐ Yes ☐ No Does your child take fluoride supplements? ☐ Yes ☐ No

Does your child:

- Suck thumb/finger ☐ Yes ☐ No
- Suck/Bite lip ☐ Yes ☐ No
- Bite/Chew nails ☐ Yes ☐ No
- Chew hard objects (pencils, etc.) ☐ Yes ☐ No
- Grind teeth ☐ Yes ☐ No
- Clench jaws ☐ Yes ☐ No

Previous dentist ______ Address ______

Date of last dental visit? ______

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Child's physician ______ Address ______

Phone # ______

Previous Hospitalizations/Surgeries/Serious Illnesses? ______ When? ______

Is your child currently taking medications? ☐ Yes ☐ No (if yes, please list) ______

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? ☐ Yes ☐ No (if yes, please describe) ______

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? ______

Has your child ever had any of the following:

- Acid Reflux ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Asthma ☐ Yes ☐ No
- Autism Spectrum Disorder ☐ Yes ☐ No
- Blood Transfusion ☐ Yes ☐ No
- Cancer ☐ Yes ☐ No
- Convulsions/Epilepsy ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Food Allergies ☐ Yes ☐ No
- Handicaps/Disabilities ☐ Yes ☐ No
- Hearing Impairment ☐ Yes ☐ No
- Heart Problems ☐ Yes ☐ No
  Describe ______
- Hemophilia (Abnormal Bleeding) ☐ Yes ☐ No
- Hepatitis ☐ Yes ☐ No
- HIV/AIDS ☐ Yes ☐ No
- Persistent Cough ☐ Yes ☐ No
- Rheumatic Fever ☐ Yes ☐ No
- Stomach, liver or kidney problems ☐ Yes ☐ No
- Tuberculosis ☐ Yes ☐ No

Please explain any medical problems that your child has: ______

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

______ ______
Signature of patient (or parent/guardian if minor) Date

Dentist Review:

______ ______
Signature of Dentist Date