

FOR CHILDREN: WELCOME TO OUR PRACTICE

| 1.) TELL US ABOUT YOUR CHILD | | | |
|------------------------------|-------------|---|------------|
| Today's date: _____ | | DOB: _____ | |
| Child's Name: _____ | | Age: _____ | |
| | | | |
| Last _____ | First _____ | MI _____ | |
| Nickname _____ | | <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| School: _____ | | Grade: _____ | |
| Home #: _____ | | | |
| SS #: _____ | | | |
| Child's Home Address: | | | |
| | | | Apt# _____ |
| City _____ | State _____ | Zip _____ | |
| Siblings: | | | |
| Name _____ | | Age _____ | |
| Name _____ | | Age _____ | |

| 4.) RESPONSIBLE PARTY INFO: | | |
|--------------------------------------|-------------|------------|
| Name: _____ | | |
| Billing Address: _____ | | |
| | | |
| City _____ | State _____ | Zip _____ |
| WK#: _____ | Ext. _____ | HM#: _____ |
| Cell #: _____ | | |
| Email: _____ | | |
| Employer: _____ | | |
| DL#: _____ | | |
| SS#: _____ | | |
| Who is responsible for making appts? | | |
| Name: _____ | | |
| WK#: _____ | Ext. _____ | HM#: _____ |

| 2.) WHO IS WITH THE CHILD TODAY? |
|---|
| Name: _____ |
| Relation: _____ |
| Do you have legal custody of this child? |
| YES NO |
| Who may we thank for referring you? _____ |
| |
| Other family members seen by us: |
| |
| Previous/Present Dentist: |
| Street: _____ |
| Phone #: _____ Last Visit: _____ |
| Parent's Marital Status: _____ |
| (single, married, divorced) |

| 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 |

| 3.) MOTHER'S INFORMATION |
|----------------------------------|
| Name: _____ |
| WK#: _____ Ext. _____ HM#: _____ |
| Employer: _____ |
| DL#: _____ |
| SS#: _____ |
| FATHER'S INFORMATION: |
| Name: _____ |
| WK#: _____ Ext. _____ HM#: _____ |
| Employer: _____ |
| DL#: _____ |
| SS#: _____ |

6.) Why did you bring the child to the dentist today?

Has the child ever had a serious/difficult problem associated with dental work? Y N

Is the child's water fluoridated? Y N

Is the child taking fluoridated supplements? Y N

Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Y N

Does the child brush teeth daily? Y N

Floss their teeth daily? Y N

Child's Physician: _____

Phone#: _____ Last visit: _____

Is the child currently under the care of a physician? Y N

Please describe the child's health: GOOD FAIR POOR

Please list all drugs the child is currently taking: _____

Please list all drugs the child is allergic to: _____

7.) Has the child ever had any of the following medical problems?

| | |
|------------------|------------------------------|
| Y N Heart Murm. | Y N Congenital Heart Def. |
| Y N Cancer | Y N Convulsions/Epilepsy |
| Y N Diabetes | Y N Abnormal Bleeding |
| Y N Rheum. Fev. | Y N Hearing Impairment |
| Y N HIV+/AIDS | Y N Any Operations |
| Y N Hemophilia | Y N Any Stays in hospital |
| Y N Asthma | Y N Kidney/Liver problems |
| Y N Hepatitis | Y N Handicaps/Disabilities |
| Y N Tuberculosis | Y N Allergies to any Drugs |
| Y N Prosthesis | Y N History of Scarlet Fever |

Please discuss any serious medical problems that the child has had:

8.) Does the child have any of the following habits?

Y N Thumb sucking / Finger sucking
Y N Lip sucking / biting
Y N Nail Biting
Y N Nursing Bottle Habits

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

9.) 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 in 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 time of service unless prior arrangements have been approved.

OFFICE USE ONLY – OFFICE USE ONLY – OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent/guardian & patient named herein.

Initials: _____ Date: _____

Doctor's comments: _____

Medical History Update

1. Date: _____ Signature: _____

Comments: _____

2. Date: _____ Signature: _____

Comments: _____