Welcome

Date: ________________

Child's First Name ________________________ Last Name: _________________ Nickname: __________

Birthdate: _______________________ Age: ________ Sex: ________ Height: ______ Weight: ______

Mailing Address: ____ City/Zip Code: _______________

Home Phone: ______________________ Cell Phone: _________________ Email: ____________________

Who is Accompanying the Child Today/Relationship: ____

Parent's Marital Status: ____ Single ______Married _____ Separated ____ Divorced ______Widowed

Who Does the Child Live With? ____

Father's Name: ___________________________ Date of Birth: _______________ Soc. Sec #: __________

Occupation: _____________________________ Employer: _________________ Work Phone: __________

Mother's Name: ___________________________ Date of Birth: _______________ Soc. Sec #: __________

Occupation: _____________________________ Employer: __________________ Work Phone: __________

Primary Insurance: ______________________________________ Name of Insured: _________________

Insured's Social Security Number: ____________________________ Group Number: _________________

Relationship to Patient: ___________________________________ Date of Birth: __________________

Secondary Insurance: _____________________________________ Name of Insured: _________________

Insured's Social Security: __________________________________ Group Number _________________

Relationship to Patient: ____________________________________ Date of Birth: _________________

Why did you bring your child to the dentist today? ____

Date of last visit to dentist: _______________________ For what services: _________________________

Any Mouth Habits: __ Thumbsucking __Nail/Lip Biting __ Nursing Bottle Habit __Pacifier ___Mouth Breathing

Any Injury to: ____ Teeth ___ Mouth ___Head

Explain: ____

Any: ___ Headaches ___ Bruxism ___ Jaw Joint Problems

Explain: ____

Any Unhappy Dental Experiences: ____

Any Unusual Speech Habit: ____

Has the child complained about dental problems? ______________________________

Does the child brush daily? How often: ______________________________

Do you assist child with toothbrushing? ______________________________

Is fluoride taken in any form? ______________________________

Has anyone in the family ever had orthodontics? ______________________________

Child's Attitude Toward Dentistry: ___ Positive ___ Negative ___ Apprehensive ___ Don't Know

Medical History

Child's Physician: ______________________ Phone Number: __________

Address: ______________________________

Date of Last Examination: __________ Results: __________

Please List All Medications That Your Child is Taking: ______________________________

Please List All Drugs That Your Child is Allergic to: ______________________________

Child attends what school: ______________________ Grade: __________

Child's Favorite Character: __________ Sport: __________ Movie: __________

Name and Ages of Siblings: ______________________________

Other Family Members Seen by us: ______________________________

Yes	No	
__	__	Is the child under the care of physician
__	__	Is there excessive bleeding when cut
__	__	Does the child have good physical coordination
__	__	Has the child ever been hospitalized
__	__	Has the child ever had surgery

Does The Child Have Any History or Difficulty With Any Of The Following:

Yes	No		Yes	No	
__	__	Anemia	__	__	Hearing
__	__	Asthma	__	__	Heart/Heart Murmur
__	__	Cancer	__	__	Hepatitis
__	__	Cerebral Palsy	__	__	HIV/AIDS
__	__	Chicken Pox/Measles/Mumps	__	__	Kidney/Liver

Yes	No		Yes	No	
___	___	Convulsions	___	___	Rheumatic Fever
___	___	Diabetes	___	___	Sickle Cell Anemia
___	___	Epilepsy	___	___	Thyroid
___	___	Fainting	___	___	Tuberculosis
___	___	Handicap/Disability	___	___	ADHD/ADD

Please list any other medical history or difficulties: ____

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Please describe any current medical treatment including drugs, pending surgery, recent injury, or any other information I should be aware of that has not been addressed above: ____

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Person Financially Responsible: ______________________________ Phone Number: ______________

Mailing Address: ____

___ Yes ___ No May we request release of your child's medical records for our references?

I understand that the information that I have given is correct to the best of my knowledge 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 that my child may need.

____ ______________________

Signature of Parent or Guardian **Date**