Welcome!

We would like to welcome you and your child to our office.
Our goal is to make every child's visit pleasant and educational.
Our practice is based on preventive care.
We strive to teach good oral care that will enable your child
to have a beautiful smile that last a lifetime.

ABOUT YOUR CHILD

Name: _____
LAST FIRST INITIAL

Nickname: _____

Birthdate: _____ ❑ Male ❑ Female
MONTH DAY YEAR

Social Security #: _____

Special interest, sports or hobbies: _____

Home address: _____

_____
APT./CONDO CITY STATE ZIP CODE

Home phone: _____

Referred by: _____

ABOUT YOU

Your name: _____

Social Security #: _____

Relationship to child: _____

Your home phone and address, if different from child's:

_____
HOME PHONE

_____
ADDRESS:

_____
APT/CONDO CITY STATE ZIP CODE

Occupation: _____

Employer: _____

Work Phone: _____ Ext.: _____

Beeper / Mobile phone: _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group #: _____

This Dental Insurance is provided through:

Their name: _____

Relationship to child: _____

Their name: _____

Relationship to child: _____

Their Social Security #: _____

Their Birthdate: _____

Their Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group #: _____

This Dental Insurance is provided through:

Their name: _____

Relationship to child: _____

Their name: _____

Relationship to child: _____

Their Social Security #: _____

Their Birthdate: _____

Their Employer: _____

DENTAL / MEDICAL HISTORY

Has your child been to the dentist before? ❑ Yes ❑ No

If yes, the approximate date of last visit: _____

Are there any dental problems that you are aware of at present?

❑ Yes ❑ No If yes, please explain: _____

_____

Does your child brush his/her teeth daily? ❑ Yes ❑ No

Please rate your child's oral health: ❑ Good ❑ Fair ❑ Poor

Is your child currently under the care of physician? ❑ Yes ❑ No

Child's Physician: _____

Their Phone#: _____

The approximate date of last visit: _____

Please rate your child's medical health. ❑ Good ❑ Fair ❑ Poor

Is your child allergic to any drugs? ❑ Yes ❑ No

If yes, please list: _____

Is your child taking any prescription drugs? ❑ Yes ❑ No

If yes, please list: _____

Does your child need to be premedicated before

dental treatment? ❑ Yes ❑ No

Has your child ever had any of the following medical conditions or problems?

(Please circle)

Y	N	Heart Murmur
Y	N	Heart problems of any kind.
Y	N	Convulsions / Epilepsy
Y	N	Cancer
Y	N	Diabetes
Y	N	Rheumatic Fever
Y	N	HIV+ / AIDS
Y	N	Hemophilia
Y	N	Bleeding problems of any kind.
Y	N	Hearing Impairment
Y	N	Hyperactive
Y	N	Any Operations
Y	N	Any stays in hospital.

Are there any other medical conditions or problems relating to your child? ❑ Yes ❑ No

If yes, please list: _____

_____

In the event of an emergency, who should we contact?

Name: _____

Relationship: _____

Phone: _____

Phone#2: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of 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 may need.

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Signature of parent or guardian:

_____

Signature Date

Thank you for filling out this form completely. It will enable us to give your child the best dental care possible. If you or your child have any questions, please feel free to ask us at any time...