

Welcome to our practice

About Your Child

Child's name: _____ Nick name: _____

Age: ___ DOB: _____ Sex: _____

Reason for visit: _____ Referred by: _____

Best number to call and confirm your child's next appt: _____

Email Address: _____

May we confirm your appointment by email? yes no

Preventive Dental History

How often does your child brush? _____ Is toothbrushing supervised? ___ By whom? _____ Is dental floss used? _____

Does your child receive: Fluoride in vitamins, fluoride in tablets/drops, fluoridated water, bottled water or well water?

Dental History

Is today your child's first dental visit? ___ Previous dentist? _____

Date of last cleaning? _____ Date of last x-rays? _____

Any injuries to your child's teeth or jaws? _____

_____ When? _____

History of:

___ Breast feeding

___ Bottle habits

___ Thumb/finger sucking

___ Pacifier

___ Dental grinding or clenching

Date:

Is there anything that would be calming to talk to your child about while in the dental office? Baseball, dance, soccer : _____

Medical History

Has your child had any of the following medical problems?

- Asthma
 - Cancer
 - Congenital Heart Failure
 - Convulsion/Epilepsy
 - Diabetes
 - Handicaps/Disabilities
 - Hearing Impaired
 - Heart Murmur
 - HIV/Aids
 - Tuberculosis
- *Child's Physician: _____
 *Physician's number: _____
 *Is your child allergic to any medications? _____
 *Is your child currently taking any medications? _____
 *Is there and medical problems you would like to let us know about at this time? _____

Dental Insurance

Primary Insurance: _____ Group#: _____
 Policy holders name: _____ Membership #: _____
 Employer: _____ DOB: _____ SS#: _____

Secondary Insurance: _____ Group #: _____
 Policy holders name: _____ Membership #: _____
 Employer: _____ DOB: _____ SS#: _____

Responsible Party

Do you have legal custody of this child? _____ Any other family members seen by us? _____

(Father) (Stepfather) or (Legal guardian) Name: _____
 Work#: _____ Home #: _____ Cell#: _____
 DOB: _____ SS#: _____ Occupation: _____
 Address: _____ City: _____ State: _____ Zip: _____

(Mother) (Stepmother) or (Legal guardian) Name: _____
 Work#: _____ Home #: _____ Cell#: _____
 DOB: _____ SS#: _____ Occupation: _____
 Address: _____ City: _____ State: _____ Zip: _____

I authorize the dental staff to perform the necessary dental services my child may need. I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____ Date: _____