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 lasts a lifetime.**

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

1 ABOUT YOUR CHILD

Name: ______________________
Last First Initial

Nickname: ______________________

Birthdate: ____________ ☐ Male ☐ Female

SS #: ____________ Age: ________

Special interests, sports or hobbies:

____

Home address: ______________________

____
City State Zip

Home phone: ______________________

Referred by: ______________________

2 ABOUT YOU

Your name: ______________________

Birthdate: ____________

SS #: ______________________

Relationship to child: ______________________

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

____
Home Phone

____
Address

____
City State Zip

Occupation: ______________________

Employer: ______________________

Work phone: ______________________

Cell phone: ______________________

3 INSURANCE

DENTAL INSURANCE COMPANY #1

Dental Ins. Co.: ______________________

Insurance Co. Phone #: ______________________

Group / Policy #: ______________________

This Dental Insurance is provided through:

Policy owner's name: ______________________

Relationship to child: ______________________

Policy owner's ID #: ______________________

Policy owner's birthdate: ______________________

Policy owner's employer: ______________________

Employer's Address: ______________________

____
City State Zip

DENTAL INSURANCE COMPANY #2

Dental Ins. Co.: ______________________

Insurance Co. Phone #: ______________________

Group / Policy #: ______________________

This Dental Insurance is provided through:

Policy owner's name: ______________________

Relationship to child: ______________________

Policy owner's ID #: ______________________

Policy owner's birthdate: ______________________

Policy owner's employer: ______________________

Employer's Address: ______________________

____
City State Zip

CONTINUED ON BACK

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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 below:

____

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 a physician? ☐ **Yes** ☐ **No**

Child's physician: ______________________________

His / Her phone #: ______________________________

The approximate date of last visit: ______________________

Please rate your child's medical health: ☐ **Good** ☐ **Fair** ☐ **Poor**

Is your child allergic to any drugs or other things? ☐ **Yes** ☐ **No**

If yes, please list: ______________________________

Is your child taking any prescription drugs? ☐ **Yes** ☐ **No**

If yes, please list: ______________________________

Does your child require antibiotics before dental treatment? ☐ **Yes** ☐ **No**

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

Y	N	Any Hospital Stays
Y	N	Any Operations
Y	N	Bleeding Problems of Any Kind
Y	N	Cancer
Y	N	Convulsions / Epilepsy
Y	N	Diabetes
Y	N	Hearing Impairment
Y	N	Heart Murmur
Y	N	Heart Problems of Any Kind
Y	N	Hemophilia
Y	N	HIV+ / AIDS
Y	N	Hyperactive
Y	N	Rheumatic / Scarlet Fever

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In the event of any emergency, whom should we contact?

Name: ____________________ Relationship: ______________

Phone: ____________________ Cell: ______________

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

If yes, please list: ____________________

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 authorize the dental staff to perform the necessary dental services my child 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: ____________________ 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.

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