Your Child's Information

Today's Date: _____/_____/_____ Child's Name: _____

Nickname: _____ Child's Birthday: _____/_____/_____ Child's Age: _____ ☐ Male ☐ Female

School: _____Grade: _____ SS #: _____/_____/_____

Child's Home # (_____) _____/_____ Hobbies Your Child Enjoy: _____

Child's Home Address: _____

Who is accompanying the child today? _____ Relation: _____

Whom may we thank for referring you? _____ Other family members seen by us: _____

Name of Previous/Current Dentist: _____ Last Dental Visit: _____/_____/_____

Dentist Phone #: (_____) _____/_____ Name of relative not living with you: _____

Address: _____ Phone # (_____) _____/_____

Parent's Information

☐ Father ☐ Step Father ☐ Guardian Name: _____ Birthday: _____/_____/_____

Home # (_____) _____/_____ Work#: (_____) _____/_____ Ext: _____ Cell#: (_____) _____/_____

SS #: _____/_____/_____ DL#:_____ Email Address: _____

Address :(If different than above) _____

Employer's Name/Address: _____

Name of Insurance Co.: _____Insurance Co. Phone #: (_____) _____/_____

Group #: _____ Insurance Co. Address: _____

☐ Mother ☐ Step Mother ☐ Guardian Name: _____ Birthday: _____/_____/_____

Home # (_____) _____/_____ Work#: (_____) _____/_____ Ext: _____ Cell#: (_____) _____/_____

SS #: _____/_____/_____ DL#:_____ Email Address: _____

Address :(If different than above) _____

Employer's Name/Address: _____

Name of Insurance Co.: _____Insurance Co. Phone #: (_____) _____/_____

Group #: _____ Insurance Co. Address: _____

Release of Information's

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits payable to me, I understand that I am responsible for payment of service rendered and also responsible for paying copayment and any deductible that my insurance does not cover. I hereby authorize this dental office to release all information necessary to secure the payments of benefits.

_____ _____

Signature of Parent/Guardian Date

Medical History

Reason for today's appointment: _____ Is your child currently in pain? Yes ☐ No ☐

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

Is the child's water fluoridated? Yes ☐ No ☐

Has the child ever had any pain/soreness in his/her jaw joints? Yes ☐ No ☐

Does the child brush his/her teeth daily? Yes ☐ No ☐

Does the child floss his/her teeth daily? Yes ☐ No ☐

Is the child currently under care of a physician? Yes ☐ No ☐ Physician's Phone#: (_____) _____/_____

Name of Medical Physician: _____ Date of Last Visit: _____/_____/_____

Your child's current physical health: Good ☐ Fair ☐ Poor ☐

Is your child currently taking any over the counter herbal supplement drugs? Yes ☐ No ☐ If yes please list medications:

_____

Please list any other drugs/items your child is allergic to: _____

Yes ☐ No ☐ Latex Yes ☐ No ☐ Metals/Nickel Yes ☐ No ☐ Plastic

Has the child experience the following medical problems?

Yes ☐	No ☐	Abnormal Bleeding	Yes ☐	No ☐	Kidney/Liver Problems
Yes ☐	No ☐	ADD/ADHD	Yes ☐	No ☐	Low Blood Pressure
Yes ☐	No ☐	Anemia	Yes ☐	No ☐	Lupus
Yes ☐	No ☐	Artificial Bones/Joints/Valves	Yes ☐	No ☐	Measles
Yes ☐	No ☐	Asthma	Yes ☐	No ☐	Mitral Valve Prolepses
Yes ☐	No ☐	Cancer	Yes ☐	No ☐	Mononucleosis
Yes ☐	No ☐	Chicken Pox	Yes ☐	No ☐	Rheumatic Fever
Yes ☐	No ☐	Congenital Heart Defects	Yes ☐	No ☐	Scarlet Fever
Yes ☐	No ☐	Convulsion	Yes ☐	No ☐	Sickle Cell Disease/Traits
Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Skin Rash
Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐	Tuberculosis (TB)
Yes ☐	No ☐	Handicaps/Disabilities			
Yes ☐	No ☐	Hearing Impairment			
Yes ☐	No ☐	Heart Murmur			
Yes ☐	No ☐	Hepatitis			
Yes ☐	No ☐	High Blood Pressure			
Yes ☐	No ☐	Hives			

Is the child immunization current? Yes ☐ No ☐

Does/did the child experience any of the following?

Yes ☐	No ☐	Breast Fed	Yes ☐	No ☐	Nursing Bottle Habits
Yes ☐	No ☐	Chewing on Objects	Yes ☐	No ☐	Speech Problems
Yes ☐	No ☐	Clenching/Grinding	Yes ☐	No ☐	Thumb/Finder Sucking
Yes ☐	No ☐	Lip Sucking/Biting	Yes ☐	No ☐	Tongue/Cheek Biting
Yes ☐	No ☐	Mouth Breather	Yes ☐	No ☐	Tongue Thrust
Yes ☐	No ☐	Nail Biting	Yes ☐	No ☐	Used Pacifier

The information I have given is correct to the best of my knowledge. It will be help in confidence and it is my responsibility to inform the dental 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.

_____ _____

Signature of Parent/Guardian Date