WELCOME

Patient Information

Child's Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Child's Preferred Name _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Sex ☐M ☐F Age _____ Birthdate _____ School _____

Grade _____ Hobbies/Sports _____

Whom may we thank for referring you? _____

Notify in case of an emergency _____ Home Phone _____

Business Phone _____ Cell Phone _____ Email _____

Mother's Information

Mother's Name _____
Last Name *First Name* *Initial*

Birthdate _____ Soc. Sec. # _____ Cell Phone _____

Address *(if different from child)* _____

City _____ State _____ Zip _____ Home Phone _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Group # _____ Subscriber # _____

Father's Information

Father's Name _____
Last Name *First Name* *Initial*

Birthdate _____ Soc. Sec. # _____ Cell Phone _____

Address *(if different from child)* _____

City _____ State _____ Zip _____ Home Phone _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Group # _____ Subscriber # _____

Please complete both sides.

Dental History

What would you like us to do for your child today? _____

_____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

How often does your child brush? _____ Floss? _____

Does your child experience pain or discomfort in the jaw joint? ☐ Y ☐ N

Has you child ever experienced a mouth or chin injury? ☐ Y ☐ N

Does your child have speech problems? ☐ Y ☐ N

Has your child ever experienced adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Child's habits affecting the mouth or teeth: ☐ thumb sucking ☐ Nail biting ☐ Other _____

Other information about your child's dental health or previous treatment _____

_____

Medical History

Child's Physician _____ Phone _____

Physician's Email _____

Date of last visit _____ Has your child had any serious illnesses or operations? ☐ Y ☐ N

If yes, describe _____

Is your child currently under physician care? ☐ Y ☐ N _____ If yes, describe _____

Has your child ever had a blood transfusion? ☐ Y ☐ N _____ If yes, give approximate dates _____

Has your child ever taken Fen-Phen/Redux? ☐ Y ☐ N

Check (✔) yes or no whether your child has had any of the following:

- ☐ Y ☐ N AIDS/HIV positive
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Atopic (allergy prone)
- ☐ Y ☐ N Blood disease
- ☐ Y ☐ N Cancer
- ☐ Y ☐ N Chicken Pox
- ☐ Y ☐ N Convulsions/Epilepsy
- ☐ Y ☐ N Cough, persistent
- ☐ Y ☐ N Cough up blood
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting
- ☐ Y ☐ N Food allergies
- ☐ Y ☐ N Headaches
- ☐ Y ☐ N Hearing impairment
- ☐ Y ☐ N Heart problems

Describe _____

- ☐ Y ☐ N Hemophilia/ Abnormal bleeding
- ☐ Y ☐ N Immunizations current
- ☐ Y ☐ N Kidney disease or malfunction
- ☐ Y ☐ N Liver disease
- ☐ Y ☐ N Material allergies (latex, wool, metal chemicals)
- ☐ Y ☐ N Respiratory disease
- ☐ Y ☐ N Rheumatic/Scarlet fever
- ☐ Y ☐ N Shortness of breath
- ☐ Y ☐ N Sinus problems
- ☐ Y ☐ N Skin rash
- ☐ Y ☐ N Spina Bifida
- ☐ Y ☐ N Thyroid disease or malfunction
- ☐ Y ☐ N Tonsillitis
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Other

Describe _____

List medications your child is taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at the time of treatment. If patient is covered by insurance, co-pay will be due. Thank you!