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
Month Day Year

SS #: _____ Age: _____

Special interests, sports or hobbies: _____

_____

_____

Home address: _____

_____
Apt/Condo # City State Zip Code

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

_____
Apt/Condo # City State Zip Code

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 SS #: _____

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 SS #: _____

Policy owner's birthdate: _____

Policy owner's employer: _____

Employer's Address: _____

_____
City State Zip

CONTINUED ON BACK

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 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**

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

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

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

Name: _____ Relationship: _____

Phone: _____ Phone #2: _____

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

If yes, please list: _____

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 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.

