

Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form. If you have questions we will be glad to help you. We look forward to working with you in maintaining your child's dental health.

Patient Information

Date _____ E-mail address _____
Name of Minor/Child _____
Sex _____ Male _____ Female Age _____ Birthdate ____/____/____
Nickname _____ Hobbies _____
Home Address _____
Mailing Address _____
Home Phone () _____ - _____ Cell phone () _____ - _____
Whom may we thank for referring you? _____

Insurance

Parent/Guardian 1 Name _____	Parent/Guardian 2 Name _____
Address (if different from patient) _____	Address (if different from patient) _____
_____	_____
Home Phone () _____ - _____	Home Phone () _____ - _____
Work Phone () _____ - _____ ext. _____	Work Phone () _____ - _____ ext. _____
Employer _____	Employer _____
Social Security Number _____ - _____ - _____	Social Security Number _____ - _____ - _____
Birthdate ____/____/____	Birthdate ____/____/____
Is there dental insurance for your child? ___Yes ___No	Is there dental insurance for your child ___Yes ___No
Plan Name _____	Plan Name _____
Phone Number () _____ - _____	Phone Number () _____ - _____
Address _____	Address _____
_____	_____
Group Number _____	Group Number _____

In situations where there is no dental insurance, please furnish us with a credit card that we may use for your child's visit?
MasterCard/Visa/American Express Card Number _____ Expiration Date ____/____

Dental History

Date of last visit to a dentist _____ For what service? _____
Has child complained about dental problems? Yes No Is fluoride take in any form? Yes No
Does child brush daily? Yes No Any injuries to mouth, teeth, head? Yes No
Does child floss daily? Yes No Any unhappy dental experiences? Yes No
Any mouth habits- thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? Yes No
If your child is here only for Orthodontics, who is their dentist? _____

Medical History

Minor/Child's Physician _____ City/State _____
Phone () _____
Date of last physical examination _____ Results _____
Is child under care of physician now? Yes No Medications _____
Receiving any medication or drugs? Yes No _____
Ever had surgery? Yes No _____
Ever been hospitalized? Yes No Allergies _____
Is there excessive bleeding when cut? Yes No _____

HAS MINOR/CHILD HAD ANY HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK ()

<input type="checkbox"/> A.I.D.S/H.I.V	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Measles	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Other _____				

Does your child need to be pre-medicated before any dental procedures? Yes No

If YES, your pharmacy name _____ Phone () _____

Authorization

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes.

Signature of Parent/Guardian _____ Date _____