Welcome

Our goal is to help you reach and maintain maximum oral health.
Please fill out this form completely.

Tell us about your Child

Today's Date ___________________

Child's Name:_______________________________________

Nickname:________________Male ____Female_________

Child's Birthdate: ___/___/____ Child's Age:____________

Child's Home Address: _______________________________

____

Child's Home# (____)_____________SS#________________

Parent's Information

____Mother_______Step Mother______Guardian

Name: _______________________________Birthdate_______

E-mail Address______________________________

Cell#(___)____________Hm#: (_____)__________________

Employer________________Wk#______________________

SS#___________________DL#: _______________________

_____Father _____Step Father ______Guardian

Name:_________________________Birthdate:___/____/_____

E-mail Address: ______________________________________

Cell# (____)_______________Hm#:_____________________

Employer:__ ______________________Wk#(____)________

SS#_______________________DL#____________________

Insurance

Primary Insurance-Dental

Insurance Co. Name____________________________________

Insurance Co. Address___________________________________

Insurance Co Phone# ___________________________________

Group # or Policy #_____________________________________

Policy Owner's Name___________________________________

Relationship to Patient:_________________________________

Policy Owner's Birthdate::____/____/.____/ID#_____________

Policy Owner's Employer:______________________ _________

Policy Owner's Address:_________________________________

Secondary Insurance-Dental

Insurance Co. Name_______________________________________

Insurance Co. Address_____________________________________

Insurance Co Phone# _____________________________________

Group # or Policy #_______________________________________

Policy Owner's Name___________________________________

Relationship to Patient:_________________________________

Policy Owner's Birthdate::____/____/.____/ID#_____________

Policy Owner's Employer:______________________ _________

Policy Owner's Address:_________________________________

Previous/Present Dentist__________________________

Last Visit Date:___________________________________

Dental History

Why did you bring the child to the dentist today? ______________________

____

Has the child ever had a serious/ difficult problem associated with previous dental work? Yes No

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? Yes No

Please list all drugs that the child is currently taken:

____

____

Aside from items listed below, list all drugs/things the child is allergic to:

____

____

Child's Physician: ______________________________________

Phone #:____________________Date of Last Visit: _________

Has the child ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N HIV+/ AIDS
Y N Anemia
Y N Hemophilia
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Epilepsy
Y N Handicaps/ Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N HIV+/AIDS
Y N Kidney/Liver Problems
Y N Measles
Y N Mononucleosis
Y N Rheumatic/Scarlet Fever
Y N Diabetes
Y N Tuberculosis (TB)

Are the Child's Immunizations current? Y N

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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.

____

Signature of parent or guardian Date

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I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein. Initials:_________Date:__________

Doctor's Comments: ____

____

Medical History Update

1. Date:____________Signature:______________________
   Comments:_______________________________________
   ____

2. Date:_________________Signature:_________________________
   Comments:____
   ____