

# 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: (\_\_\_\_) \_\_\_\_\_

# INSURANCE

# 3

## 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

4

### 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?

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

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

If yes, please list: \_\_\_\_\_

6

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

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone #2: \_\_\_\_\_



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.