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!

TELL US ABOUT YOUR CHILD

Today's Date: _____

Child's Name: _____
Last First M.I.

Child's Birthdate: _____ Child's Age: _____

Nickname: _____ ( ) Male ( ) Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: _____ SS #: _____

Child's Home Address: _____
Apt #

_____
City State Zip

GENERAL INFORMATION

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ( ) Yes ( ) No

Whom may we thank for referring you? _____

Other siblings: _____

Previous/Present Dentist: _____

Last Visit Date: _____ Dentist's Phone: _____

Relative or Friend not living with you:

Name: _____ Phone: _____

Address: _____

_____
City State Zip

PARENT'S INFORMATION

Who is responsible for account? _____ Parent's Marital Status ( ) Single ( ) Married ( ) Partnered ( ) Widowed ( ) Divorced ( ) Separated

( ) **Father** ( ) Step Father ( ) Guardian

Name: _____ Birthdate: _____

Address: (If different than Child's) Home #: _____

_____

_____

SS #: _____ DL #: _____

Wk #: _____ Ext: ____ Cell/Other #: _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

( ) **Mother** ( ) Step Mother ( ) Guardian

Name: _____ Birthdate: _____

Address: (If different than Child's) Home #: _____

_____

_____

SS #: _____ DL #: _____

Wk #: _____ Ext: ____ Cell/Other #: _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

PRIMARY INSURANCE

Subscriber's Name: _____

Patient's Relationship to Subscriber: ( ) Self ( ) Spouse ( ) Child

Subscriber ID#: _____ Subscriber's DOB: _____

Insurance Co.: _____ Phone: _____

Insurance Co. Address: _____
Street

_____
City State Zip

Employer: _____

Group Name: _____ Group #: _____

SECONDARY INSURANCE

Subscriber's Name: _____

Patient's Relationship to Subscriber: ( ) Self ( ) Spouse ( ) Child

Subscriber ID#: _____ Subscriber's DOB: _____

Insurance Co.: _____ Phone: _____

Insurance Co. Address: _____
Street

_____
City State Zip

Employer: _____

Group Name: _____ Group #: _____

RELEASE

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian **Date:**

DENTAL & MEDICAL HISTORY

Child's Name Last: _____ First: _____ Birthdate: _____

Why did you bring the child to the dentist today?

_____

_____

Has the child ever been evaluated or had orthodontic treatment before? ( ) Y ( ) N

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

Have there been any injuries to the face, mouth, teeth or chin? ( ) Y ( ) N

Have adenoids or tonsils been removed? ( ) Y ( ) N

Does your child have any missing or extra permanent teeth? ( ) Y ( ) N

Has the child ever taken any diet pills such as Phen-Fen? ( ) Y ( ) N
(Also known as Redux or Pondimin.) If so, when? _____

Is the child currently in pain? ( ) Y ( ) N

Does the child require antibiotics before dental treatment? ( ) Y ( ) N

Has the child ever had a serious/difficult problem associated with previous dental work? ( ) Y ( ) N

Is your child's water fluoridated? ( ) Y ( ) N

Is the child taking fluoridated supplements? ( ) Y ( ) N

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ( ) Y ( ) N

Does the child brush his/her teeth daily? ( ) Y ( ) N

Floss his/her teeth daily? ( ) Y ( ) N

Child's Physician: _____

Phone#: _____ Date of last visit: _____

Is the child currently under the care of a physician? ( ) Y ( ) N

Has puberty begun? ( ) Y ( ) N

Has menstruation begun? ( ) Y ( ) N

Please describe the child's current physical health: ( ) Good ( ) Fair ( ) Poor

Please list all prescription / over the counter or supplement drugs that the child is currently taking:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

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

_____

Latex ( ) Y ( ) N Metals/Nickel ( ) Y ( ) N Plastic ( ) Y ( ) N

Has the child experienced the following medical problems? **Date**

	Yes	No		Yes	No
Abnormal Bleeding	( )	( )	Heart Murmur	( )	( )
ADD/ADHD	( )	( )	Hepatitis	( )	( )
AIDS/HIV+	( )	( )	Hives/Skin Rash	( )	( )
Anemia	( )	( )	Kidney Problems	( )	( )
Any Hospital Stays/Operations?	( )	( )	Liver Problems	( )	( )
Artificial Bones/Joints/Valves	( )	( )	( ) Low ( ) High Blood Pressure	( )	( )
Asthma	( )	( )	Lupus	( )	( )
Cancer	( )	( )	Measles	( )	( )
Chicken Pox	( )	( )	Mitral Valve Prolapse	( )	( )
Congenital Heart Defect	( )	( )	Mononucleosis	( )	( )
Convulsions	( )	( )	Prosthetics	( )	( )
Diabetes	( )	( )	Rheumatic Fever	( )	( )
Epilepsy	( )	( )	Scarlet Fever	( )	( )
Exposed to HIV, but Neg.	( )	( )	Sickle Cell Disease/Traits	( )	( )
Handicaps/Disabilities	( )	( )	Stroke	( )	( )
Hearing Impairment	( )	( )	Tuberculosis (TB)	( )	( )

Are your child's immunizations current? ( ) Y ( ) N

Anything you would like to discuss with the Doctor in private? ( ) Y ( ) N

Please discuss any serious medical problems that the child has had:

_____

_____

Does/did the child experience any of the following?

	Yes	No		Yes	No
Breast Fed	( )	( )	Nursing Bottle Habits	( )	( )
Chewing on Objects	( )	( )	Speech Problems	( )	( )
Clenching/Grinding Teeth	( )	( )	Thumb/Finger Sucking	( )	( )
Lip Sucking/Biting	( )	( )	Tongue/Cheek Biting	( )	( )
Mouth Breather	( )	( )	Tongue Thrust	( )	( )
Nail Biting	( )	( )	Used Pacifier	( )	( )

List any musical instruments played: _____

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.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that 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/orthodontic services my child may need.

Signature of Parent or Guardian **Date:**

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I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Signature of Dentist **Date:**

Dentist's Comments:

MEDICAL HISTORY UPDATE

Has there been any change in your child's health status since their last visit? ( ) Y ( ) N ( ) Parent/Guardian Initial Date:

If Yes, please explain: _____ ( ) Dentist Initial Date:

_____

Has there been any change in your child's health status since their last visit? ( ) Y ( ) N ( ) Parent/Guardian Initial Date:

If Yes, please explain: _____ ( ) Dentist Initial Date:

_____