Patient ID#____________________

Today's Date____________________

Welcome

to your practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime

Your Child

Child's Name:____________________

Nickname:____________ Sex:_______

Birthdate:____________ Age:_______

SS#/SIN:____________________

School:____________ Grade:_______

Child's Home Address:____________

City:____________________

State/Prov.:____________

Zip/P.C.:____________

Phone:____________

Responsible Party

Name:____________________

Relationship:____________________

Address:____________________

SS#/SIN:____________________

DL#:____________________

Email:____________________

Phone:____________

☐ Mother

☐ Stepmother ☐ Guardian

Name:____________________

Home Phone:____________________

Work Phone:____________________

Cell Phone:____________________

SS#/SIN:____________________

Employer:____________________

Occuption:____________

DL#:________

Primary Dental Insurance

Insured's Name:____________________

Relationship:____________________

Birthday:________ SS#SIN:____________

Employer:____________ Date Emp.:__________

Occupation:____________________

Ins. Company:________________ Group#__________ Emp.#____________

Ins. Company Address:______________________________________

Deductible:________ Amount already used:_______ Max. annual benefit:________

Orthodontic coverage: ☐ Yes ☐ No

☐ Father

☐ Stepfather ☐ Guardian

Name:____________________

Home Phone:____________________

Work Phone:____________________

Cell Phone:____________________

SS#/SIN:____________________

Employer:____________________

Occuption:____________

DL#:________

Additional Insurance

Insured's Name:________________ Relationship:________________

Birthday:__________ SS#SIN:________________ Employer:________________

Date Emp.:__________ Occupation:______________________________

Ins. Company:________________ Group#__________ Emp.#________

Ins. Company Address:______________________________________

Deductible:________ Amount already used:____________

Max. annual benefit:________________

Orthodontic coverage:

☐ Yes ☐ No

Parent's Marital Status

☐ Single ☐ Divorced ☐ Married

☐ Widowed ☐ Separated

Who is Responsible for making appointments?

Name:______________________________

Home Phone:______________________________

Work Phone:________________ Ext.:__________

Cell Phone:______________________________

Best time to call (Time):__________ (Days):__________

Health History

Your child's overall health as well as any medications Which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has your child had difficulty with previous visits?________________________

Does your child have history of allergies to any substances (latex,environmental, etc.)?__________

Has your child ever had any of the followings:

- Acid Reflux: ☐YES ☐NO
- Alergies: ☐YES ☐NO
- Anemia: ☐YES ☐NO
- Asthma: ☐YES ☐NO
- Blood Transfusion: ☐YES ☐NO
- Cancer: ☐YES ☐NO
- Convulsions: ☐YES ☐NO
- Diabetes: ☐YES ☐NO
- Hearing Impairment: ☐YES ☐NO
- Heart Problems: ☐YES ☐NO
- Abnormal Bleeding: ☐YES ☐NO
- Hepatitis: ☐YES ☐NO
- HIV/AIDS: ☐YES ☐NO
- Persistent Cough: ☐YES ☐NO
- Rheumatic Fever: ☐YES ☐NO
- Tuberculosis: ☐YES ☐NO
- Handicaps/Disabilities: ☐YES ☐NO

Please explain any medical problems that your child has

____

____

____

____

____

____

Child's Habits

How often does your child brush?________________________

How often does your child floss?________________________

Date of last dental visit________________________

Previous Dentist________________________

Child's Physician________________________

Phone Number________________________

Child's Birthdate________________________

Is your child's water fluoridated? ☐YES ☐NO

Does your child take fluoride supplements? ☐YES ☐NO

Does your child:

- Suck thumb/finger ☐YES ☐NO
- Suck/Bite lips ☐YES ☐NO
- Bite/Chew nails ☐YES ☐NO
- Chew hard objects (Pencils, etc.) ☐YES ☐NO
- Grind Teeth ☐YES ☐NO
- Clench Jaws ☐YES ☐NO

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in m y child's medical status. I authorize the dentist to release any information including the diagnosis and the record of any treatment of examination rendered to my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurnace carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X________________________

Signature of patient or parent/guardian if minor

____

Date

Dentist's Review

____

____

____

____

Date________________________

Signed Dr.________________________

Health History update

Date________________________

Comments________________________

____

Signature________________________

Date____________ Comments________________________

____

Signature________________________