Welcome Kids!

Please print this form, fill it out completely and bring it with you to your first office visit., Thank you!

1 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: _____

Home #: ( )_____ Child's SSN _____

Child's Home Address: _____

_____
City State Zip

2 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 referriong you? _____

Other siblings: _____

Previous/Present Dentist: _____ Last Visit: _____

Dentist's Phone #: (_____)_____

Relative or friend not living with you:

Name:_____ Phone (_____)_____

Address:_____

_____
City State Zip

3 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 #: (_____)_____

_____

_____

SSN: _____ DL#: _____

Wk#: (_____)_____Ext:_____ Cell/Other#: (_____)_____

Email:_____

Employer: _____

Employer Address: _____

_____

If you have Dental Insurance for the child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone: (_____)_____

Group # (Plan, Local, or Policy #): _____

❑ Mother ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: ___/___/_____

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

_____

_____

SSN: _____ DL#: _____

Wk#: (_____)_____Ext:_____ Cell/Other#: (_____)_____

Email:_____

Employer: _____

Employer Address: _____

_____

If you have Dental Insurance for the child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone: (_____)_____

Group # (Plan, Local, or Policy #): _____

4 Release

I certify that my child is covered by _____ Insurance Company 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

5 Dental History

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

_____

_____

Has the child ever taken any diet pills such as Phen-Phen? ❑ Yes ❑ No
(Also knwn as Redux or Pondimin) If so, when? _____

Is the child currently in pain? ❑ Yes ❑ No

Does the child require antibiotics before dental treatment? ❑ Yes ❑ No

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

Is the child's water flouridated? ❑ Yes ❑ No

Is the child taking flouridated supplements? ❑ Yes ❑ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Does the child brush his/her teeth daily? ❑ Yes ❑ No

Floss his/her teeth daily? ❑ Yes ❑ No

Child's Physician: _____

Phone #: _____ Last Visit: _____

Is the child currently under the care of a physician? ❑ Yes ❑ No

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

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

_____

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

_____

Latex ❑ Yes ❑ No Metals/Nickel ❑ Yes ❑ No Plastic ❑ Yes ❑ No

6 Medical History

Has the child experienced any of the following medical problems?

Y N Abnormal Bleeding/Hemophilia	Y N Heart Murmur
Y N ADD / ADHD	Y N Hepatitis
Y N AIDS / HIV+	Y N High Blood Pressure
Y N Anemia	Y N Hives
Y N Any Hospital Stays/Operations?	Y N Kidney Problems
Y N Artificial Bones/Joints/Valves	Y N Liver Problems
Y N Asthma	Y N Low Blood Pressure
Y N Cancer	Y N Lupus
Y N Chicken Pox	Y N Measles
Y N Congenital Heart Disease	Y N Mitral Valve Prolapse
Y N Convulsions	Y N Mononucleosis
Y N Diabetes	Y N Prosthetics
Y N Epilepsy	Y N Rheumatic / Scarlet Fever
Y N Exposed to HIV but Neg.	Y N Skin Rash
Y N Handicaps / Disabilities	Y N Tuberculosis (TB)
Y N Hearing Impairment	

Are the child's immunizations current? ❑ Yes ❑ No
Anything you would like to discuss with the Doctor in private? ❑ Yes ❑ No
Please discuss any serious medical problems the child experiences/ed:

_____

_____

Does / did the child experience any of the following?

Y N Breast Fed	Y N Nursing Bottle Habits
Y N Chewing on Objects	Y N Speech Problems
Y N Clenching/Grinding Teeth	Y N Thumb / Finger Sucking
Y N Lip Sucking / Biting	Y N Tongue/Cheek Biting
Y N Mouth Breather	Y N Tongue Thrust
Y N Nail Biting	Y N Used a Pacifier

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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 ikn 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 of the patient named herein. _____
Signature of Dentist Date

Dentist's Comments: _____

_____

_____

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? ❑ Y ❑ N
If Yes, please explain: _____

_____

Parent/Guardian Signature Date

Dentist Signature Date

Has there been any change in your health status since your last visit? ❑ Y ❑ N
If Yes, please explain: _____

_____

Parent/Guardian Signature Date

Dentist Signature Date