



**For Office Use Only**

I verbally reviewed the medical/dental information below with the parent/guardian and patient named herein.

Initials	Date / /	Insurance: Effective Dat / /	<input type="radio"/> Preventive <input type="radio"/> Major <input type="radio"/> Maximum	<input type="radio"/> Deductible Basic <input type="radio"/> Electronic Claims
Does insurance cover sealants? If yes, what do they fall under?			Doctor's Comments	
<input type="radio"/> Yes <input type="radio"/> No				

**1 CHILD'S INFORMATION**

Child's Full Name: Last, First, MI, Nickname		<input type="radio"/> Male <input type="radio"/> Female	Birthday / /	Age	Height	Weight
Child's Home Phone Number: ( )	Child's Home Address: Street, City, State, Zip					
Child's Social Security Number:	Has any member of your family been a patient in this office? If yes, Name					
Child's Siblings: Name	Age	Name	Age	Name	Age	

**2 MOTHER'S INFORMATION**

Mother's Name: Last, First, MI		<input type="radio"/> Stepmother <input type="radio"/> Guardian	Birthday / /
Employer: Company name and Occupation	Social Security #		Drivers License #
Home Address: Street, City, State, Zip		Home Phone: ( )	
Work Phone: ( )	Ext.	Cell Phone: ( )	Email Address:

**3 FATHER'S INFORMATION**

Father's Name: Last, First, MI		<input type="radio"/> Stepfather <input type="radio"/> Guardian	Birthday / /
Employer: Company name and Occupation	Social Security #		Drivers License #
Home Address: Street, City, State, Zip		Home Phone: ( )	
Work Phone: ( )	Ext.	Cell Phone: ( )	Email Address:

**4 PERSON RESPONSIBLE FOR ACCOUNT**

Name: Last, First, MI		Relationship to Child	Birthday / /
Employer: Company name and Occupation	Social Security #		Drivers License #
Billing Address: Street, City, State, Zip		Home Phone: ( )	
Work Phone: ( )	Ext.	Cell Phone: ( )	Email Address:

**5 PRIMARY DENTAL INSURANCE**

Insurance Co. Name:	
Insurance Co. Address: Street, City, State, Zip	
Insurance Company Phone Number: ( )	Group # (plan, local, or policy #)

**Policy Owners Information:**

Name: Last, First	Relation to Patient:
Social Security Number:	Birthday / /
Employer:	

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## CHILD'S DENTAL HISTORY

Is this your child's first visit to the dentist? <input type="radio"/> Yes <input type="radio"/> No	If not, how long since the last visit?	Name of previous dentist:	Name of family dentist:
Were any x-rays taken at previous dental visits? <input type="radio"/> Yes <input type="radio"/> No	Have there been any injuries to the teeth, face or mouth? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain.		
What is the purpose of today's visit?		Any pain or tenderness in jaw/joint? (TMJ/TMD)? If yes, please explain. <input type="radio"/> Yes <input type="radio"/> No	
Has the child ever had a serious or difficult problem associated with previous dental work? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain.			How do you think your child will react to their dental visit? <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor
<input type="radio"/> Yes <input type="radio"/> No Is the child's water fluoridated?	<input type="radio"/> Yes <input type="radio"/> No Floss his/her teeth daily?	<input type="radio"/> Yes <input type="radio"/> No Does child brush teeth daily?	
<input type="radio"/> Yes <input type="radio"/> No Is the child taking fluoride supplements?	<input type="radio"/> Yes <input type="radio"/> No Supervised while caring for teeth?	By whom	Times per day
Does Your Child Have Any Of The Following Habits?			
<input type="radio"/> Yes <input type="radio"/> No Lip Sucking/Biting	<input type="radio"/> Yes <input type="radio"/> No Nursing Bottle Habits	<input type="radio"/> Yes <input type="radio"/> No Pacifier	<input type="radio"/> Yes <input type="radio"/> No Mouth Breather
<input type="radio"/> Yes <input type="radio"/> No Nail Biting	<input type="radio"/> Yes <input type="radio"/> No Thumb/Finger Sucking	<input type="radio"/> Yes <input type="radio"/> No Breathing Issues	

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## CHILD'S HEALTH HISTORY

Has The Child Ever Had Any Of The Following Conditions?

<input type="radio"/> Yes <input type="radio"/> No Abnormal Bleeding	<input type="radio"/> Yes <input type="radio"/> No Hepatitis	<input type="radio"/> Yes <input type="radio"/> No Artificial Joint
<input type="radio"/> Yes <input type="radio"/> No Handicaps/Disabilities	<input type="radio"/> Yes <input type="radio"/> No Cancer	<input type="radio"/> Yes <input type="radio"/> No Hypertension
<input type="radio"/> Yes <input type="radio"/> No Allergies to any drugs	<input type="radio"/> Yes <input type="radio"/> No HIV +/-AIDS	<input type="radio"/> Yes <input type="radio"/> No Blood Disorder
<input type="radio"/> Yes <input type="radio"/> No Hearing Impairment	<input type="radio"/> Yes <input type="radio"/> No Congenital Heart Disease	<input type="radio"/> Yes <input type="radio"/> No Dysrhythmias
<input type="radio"/> Yes <input type="radio"/> No Premature Birth	<input type="radio"/> Yes <input type="radio"/> No Kidney/Liver Conditions	<input type="radio"/> Yes <input type="radio"/> No Mitral Valve Prolapse
<input type="radio"/> Yes <input type="radio"/> No Any hospital stays	<input type="radio"/> Yes <input type="radio"/> No Convulsions/Epilepsy	<input type="radio"/> Yes <input type="radio"/> No Drug Sensitivities
<input type="radio"/> Yes <input type="radio"/> No Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No Rheumatic/Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No Anemia
<input type="radio"/> Yes <input type="radio"/> No Any Operations	<input type="radio"/> Yes <input type="radio"/> No Pregnancy	<input type="radio"/> Yes <input type="radio"/> No Brain Injury
<input type="radio"/> Yes <input type="radio"/> No Hemophilia	<input type="radio"/> Yes <input type="radio"/> No Allergies to Latex	<input type="radio"/> Yes <input type="radio"/> No Angina
<input type="radio"/> Yes <input type="radio"/> No Asthma	<input type="radio"/> Yes <input type="radio"/> No Seasonal Allergies	
<input type="radio"/> Yes <input type="radio"/> No Respiratory or breathing problems	<input type="radio"/> Yes <input type="radio"/> No Prior Anesthesia complications	

Please discuss any serious medical conditions the child has had:

Please list all the drugs the child is currently taking: (Rx, non-Rx), Dosage, Intervals

Is the child allergic to any food or medicine?

Child's Physician: Address, Phone number

Date of last visit:

Is the child currently under the care of a physician?

 Yes  No If yes, please list what conditions

Child's current physical health:

 Good  Fair  Poor

How did you hear about our office?

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## EMERGENCY CONTACT

Name: Last, First, Relationship to child	Home Phone: ( )	Work Phone: ( )	Cellular Phone: ( )
Address: Street, City, State, Zip			

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 co-payment 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 of my

insurance submissions, whether manual or electronic. I understand that the information 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. I hereby authorized direct payment to my dentist for dental benefits otherwise payable to me.

Signature of Parent or Guardian

X

Date

/ /

Relation to Patient