

# WELCOME

## 1

### About Your Child

Today's Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Child's Name: \_\_\_\_\_  
LAST FIRST M.I.

Child's Nickname: \_\_\_\_\_  Boy  Girl

Child's Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Child's Home Phone #: (\_\_\_\_\_) \_\_\_\_\_

Child's SS#: \_\_\_\_\_

Child's Address: \_\_\_\_\_  
HOME ADDRESS

\_\_\_\_\_  
CITY STATE ZIP

Referred By: \_\_\_\_\_  
(IF DOCTOR, PLEASE GIVE ADDRESS & PHONE NUMBER)

## 2

### Insurance Info

#### PRIMARY DENTAL INSURANCE

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
CITY STATE ZIP

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

Insured's SS#: \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Insured's Employer: \_\_\_\_\_

#### SECONDARY DENTAL INSURANCE

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
CITY STATE ZIP

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

Insured's SS#: \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Insured's Employer: \_\_\_\_\_

## 3

### Child's Family Info

Who is accompanying this child today?

\_\_\_\_\_  
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have legal custody of this child?  Yes  No

How many brothers/sisters? \_\_\_\_\_ Age(s): \_\_\_\_\_

Mother's Name: \_\_\_\_\_  
 STEP MOTHER  GUARDIAN

CHECK IF SAME AS CHILD'S HOME ADDRESS CITY STATE ZIP

(\_\_\_\_\_) \_\_\_\_\_  
HOME PHONE # WORK PHONE # EXTENSION

\_\_\_\_\_  
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S CELL #

Employer: \_\_\_\_\_ How long? \_\_\_\_\_

\_\_\_\_\_  
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: \_\_\_\_\_  
 STEP FATHER  GUARDIAN

CHECK IF SAME AS CHILD'S HOME ADDRESS CITY STATE ZIP

(\_\_\_\_\_) \_\_\_\_\_  
HOME PHONE # WORK PHONE # EXTENSION

\_\_\_\_\_  
FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S CELL #

Employer: \_\_\_\_\_ How long? \_\_\_\_\_

\_\_\_\_\_  
EMPLOYER'S ADDRESS CITY STATE ZIP

## 4

### Account Info

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_  
RELATION TO CHILD

Billing Address: \_\_\_\_\_

\_\_\_\_\_  
CITY STATE ZIP

\_\_\_\_\_  
SOCIAL SECURITY # DATE OF BIRTH

(\_\_\_\_\_) \_\_\_\_\_  
WORK PHONE # CELL PHONE #

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# 5

## Child's Dental Info

Reason for today's visit:  Exam  Emergency  Consultation

Is child in pain?  No  Yes How long? \_\_\_\_\_

Please indicate  any of the following problems:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Discomfort, clicking or popping in jaw | <input type="checkbox"/> Lost/broken filling(s) | <input type="checkbox"/> Stained teeth |
| <input type="checkbox"/> Red, swollen or bleeding gums          | <input type="checkbox"/> Teeth grinding         | <input type="checkbox"/> Locking jaw   |
| <input type="checkbox"/> Sensitive tooth, teeth or gums         | <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Bad breath    |
| <input type="checkbox"/> Blisters/sores in or around the mouth  | <input type="checkbox"/> Broken/chipped tooth   | <input type="checkbox"/> Loose tooth   |
| <input type="checkbox"/> Other(s): _____                        |   |  |

Does child require pre-medication?  Yes  No  Don't know

Previous dentist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Last dental exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last dental x-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_

Times a day child brushes? \_\_\_\_\_ Times a week child flosses? \_\_\_\_\_ Is the child's water fluoridated?  Yes  No

How would you rate the child's smile? **WORST** 1 2 3 4 5 6 7 8 9 10 **BEST**

# 6

## Child's Medical History

Is child taking any of the following medications?  Pain killers (including aspirin)  Ritalin  Stimulants  Blood thinners  
 Tranquilizers  Muscle relaxers  Insulin  Others: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

DOCTOR'S NAME OR CLINIC NAME

ADDRESS CITY STATE ZIP Last medical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Does child have or ever had any of the following diseases, medical conditions or procedures?

- |                                    |  |  |
|------------------------------------|--|--|
| <b>Y N</b> Heart murmur            | <b>Y N</b> Tonsillitis                 | <b>Y N</b> High/low blood pressure         |
| <b>Y N</b> Rheumatic fever         | <b>Y N</b> Respiratory problems        | <b>Y N</b> Hepatitis                       |
| <b>Y N</b> Artificial heart valves | <b>Y N</b> Asthma/difficulty breathing | <b>Y N</b> Artificial bones/joint implants |
| <b>Y N</b> Congenital heart defect | <b>Y N</b> Blood transfusion(s)        | <b>Y N</b> Liver/kidney/organ problems     |
| <b>Y N</b> Scarlet fever           | <b>Y N</b> Leukemia/anemia             | <b>Y N</b> HIV+/AIDS/ARC                   |
| <b>Y N</b> Surgeries/operations    | <b>Y N</b> Diabetes/hypoglycemia       | <b>Y N</b> Tuberculosis TB                 |
| <b>Y N</b> Cancer/tumors           | <b>Y N</b> Hemophilia                  | <b>Y N</b> Psychiatric problems            |
| <b>Y N</b> Chemotherapy            | <b>Y N</b> Abnormal bleeding           | <b>Y N</b> Hyper active/ADD                |
| <b>Y N</b> Jaw problems TMJ/TMD    | <b>Y N</b> Cleft lip/palate            | <b>Y N</b> Fainting/seizures/epilepsy      |
| <b>Y N</b> Hearing problems        | <b>Y N</b> Birth defects               | <b>Y N</b> Cerebral palsy                  |

Please list any other medical condition(s) child has or ever had: \_\_\_\_\_

Is child allergic to:  Latex  Penicillin/Amoxycillin  Tetracycline  Dental Anesthetics (Novacaine)  Aspirin  
 Food allergies  Other(s): \_\_\_\_\_

Please rate the child's general health from 1 - 10: \_\_\_\_\_ Does child wear contact lenses?  Yes  No

Has your child ever taken the drug Ritalin (or similar drug)?  No  Yes How long? \_\_\_\_\_

Does your child do any of the following?  Thumb/finger sucking  Tongue thrusting/sucking  Heavy snoring  
 Mouth breathing  Lip sucking/biting

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: \_\_\_\_\_  Parent or Guardian  Other Date: \_\_\_\_/\_\_\_\_/\_\_\_\_