

**FOR CHILDREN: WELCOME TO OUR PRACTICE**

<b>1.) TELL US ABOUT YOUR CHILD</b>		
Today's date: _____	DOB: _____	
<b>Child's Name:</b> _____	AGE: _____	
_____		
Last _____	First _____	Mi _____
Nickname: _____	Male   Female	
School: _____	Grade: _____	
Home #: _____		
SS #: _____		
<b>Child's Home Address:</b>		
_____		Apt# _____
_____	City _____	State _____ Zip _____
Siblings:		
Name _____	Age _____	
Name _____	Age _____	

<b>4.) RESPONSIBLE PARTY INFO:</b>
Name: _____
Billing Address: _____
_____
City _____ State _____ Zip _____
WK#: _____ Ext: _____ HM#: _____
Cell #: _____
Email: _____
Employer: _____
DL#: _____
SS#: _____
<b>Who is responsible for making appts?</b>
Name: _____
WK#: _____ Ext: _____ HM#: _____

<b>2.) WHO IS WITH THE CHILD TODAY?</b>
Name: _____
Relation: _____
Do you have legal custody of this child?
YES _____ NO _____
Who may we thank for referring you? _____
_____
Other family members seen by us? _____
_____
<b>Previous/Present Dentist:</b> _____
Street: _____
Phone #: _____ Last Visit: _____
Parent's Marital Status: _____
(single, married, divorced)

<b>5.) PRIMARY DENTAL INSURANCE</b>
Ins. Name: _____
Ins. Address: _____
_____
Insurance Co. Phone #: _____
Group/Policy # _____
_____
<b>Insured's Name:</b> _____
Relationship to Patient: _____
<b>Insured's DOB:</b> _____
<b>Insured's Employer:</b> _____
SS#: _____
Orthodontic Coverage: YES _____ NO _____
<b>SECONDARY DENTAL INSURANCE</b>
Ins. Name: _____
Ins. Address: _____
_____
Insurance Co. Phone #: _____
Group/Policy # _____
_____
<b>Insured's Name:</b> _____
Relationship to Patient: _____
<b>Insured's DOB:</b> _____
<b>Insured's Employer:</b> _____
SS#: _____
Orthodontic Coverage: YES _____ NO _____

<b>3.) MOTHER'S INFORMATION</b>
Name: _____
WK#: _____ Ext. _____ HM#: _____
Employer: _____
DL#: _____
SS#: _____
<b>FATHER'S INFORMATION</b>
Name: _____
WK#: _____ Ext. _____ HM#: _____
Employer: _____
DL#: _____
SS#: _____

**6) Why did you bring the child to the Orthodontist today?**

Has the child ever had a serious/difficult Problem associated with dental work? **Y N**

Is the child's water fluoridated? **Y N**

Is the child taking fluoridated supplements? **Y N**

**Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)?**

**Y N**

Does the child brush teeth daily? **Y N**

Floss their teeth daily? **Y N**

Child's Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_ Last visit: \_\_\_\_\_

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

Please describe the child's health:

GOOD FAIR POOR

Please list all drugs the child is currently taking: \_\_\_\_\_

Please list all drugs the child is allergic to: \_\_\_\_\_

**7) Has the child ever had any of the following medical problems?**

Y N Heart Murm. Y N Congenital Heart Def.

Y N Cancer Y N Convulsions/Epilepsy.

Y N Diabetes Y N Abnormal Bleeding

Y N Rheum. Fev. Y N Hearing Impairment

Y N HIV+/AIDS Y N Any Operations

Y N Hemophilia Y N Any Stays in Hospital

Y N Asthma Y N Kidney/Liver Problems

Y N Hepatitis Y N Handicaps/Disabilities

Y N Tuberculosis Y N Allergies to Any Drugs

Y N Prosthesis Y N History of Scarlet Fever

Please discuss any serious medical problems

That the child has had: \_\_\_\_\_

**8) Does the child have any of the following habits?**

Y N Thumb sucking/ Finger sucking

Y N Lip sucking/ biting

Y N Nail Biting

Y N Nursing Bottle habits

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

**9) I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office Of any changes in my child's medical status. I also authorize the dental staff to perform the Necessary dental services my child may need.**

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

**The parent/guardian who accompanies the child is responsible for payment at time of service unless Prior arrangements have been approved.**

**OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY**

I verbally reviewed the medical/ dental Information above with the parent/guardian & Patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Doctor's comments:** \_\_\_\_\_

**Medical History Update:**

1. Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Comments: \_\_\_\_\_

2. Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Comments: \_\_\_\_\_