Welcome to our practice!

Patient ID No. _____
Today's date _____

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 _____
E-mail _____
Birthdate _____ Age _____
SS#/SIN _____
School _____ Grade _____
Child's Home Address _____
City _____
State/Province _____ Zip/Postal Code _____
Phone _____

Mother ☐Stepmother ☐Guardian

Name _____
E-mail _____
Home Phone _____
Work Phone _____
SS#/SIN _____
Employer _____
Occupation _____

Father ☐ Stepfather ☐Guardian

Name _____
E-mail _____
Home Phone _____
Work Phone _____
SS#/SIN _____
Employer _____
Occupation _____

Parent/Guardian's Marital Status

☐ Single ☐ Married
☐ Divorced ☐ Widowed ☐ Separated

Who is responsible for making appointments?

Name _____
E-mail _____
Home Phone _____
Cell Phone _____
Work Phone _____
Best time to call (time) _____ (days) _____

Responsible Party

Name _____
E-mail _____
Relationship _____
Address _____
SS#/SIN _____

Primary Dental Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS#/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group No. _____ Emp. No. _____
Ins. Company Address _____
Deductible _____ Max. Annual Benefit _____
Orthodontic Coverage ☐yes ☐no

Additional Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS#/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group No. _____ Emp. No. _____
Ins. Company Address _____
Deductible _____ Max. Annual Benefit _____
Orthodontic Coverage ☐yes ☐no

over please

Health History

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

Health History

Has your child had any difficulty with previous visits?
Comments:_____
Has your child ever had any of the following:

Asthma	☐ yes	☐ no
Cancer/Hepatitis	☐ yes	☐ no
HIV/AIDS	☐ yes	☐ no
Hemophilia	☐ yes	☐ no
Diabetes	☐ yes	☐ no
Allergies	☐ yes	☐ no
Rheumatic Fever	☐ yes	☐ no
Congenital Heart Defect	☐ yes	☐ no
Handicaps/Disabilities	☐ yes	☐ no
Convulsions/Epilepsy	☐ yes	☐ no
Tuberculosis	☐ yes	☐ no
Abnormal Bleeding	☐ yes	☐ no
Heart Murmur	☐ yes	☐ no

Type_____

Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ☐ yes ☐ no

Has your child ever taken Fen-Phen/Redux? ☐ yes ☐ no

Please explain any medical problems that your child has _____

_____

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 my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers 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 insurance 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's parent/guardian date

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

Dentist's Review

_____
_____
_____
_____
_____
Date _____ Signed Dr. _____

Health History Update

Comments _____
_____
_____
Date _____ Signature _____
Comments _____
_____
_____
Date _____ Signature _____