



Welcome to CHILDREN'S DENTISTRY

Please fill out this form and bring it with you on your first office visit.



ABOUT YOUR CHILD

CHILD'S NAME _____

NAME CHILD PREFERS TO BE CALLED _____

AGE _____ M F _____
DATE OF BIRTH _____

WEIGHT _____ HEIGHT _____

REASON FOR VISIT _____

REFERRED TO THIS OFFICE BY (We wish to thank them):

FULL NAME _____

PHONE # _____

PREVENTIVE DENTAL HISTORY

How often does your child brush? _____

Is toothbrushing supervised? Yes No

By whom? _____

Is dental floss used? Yes No

Does your child receive:

- Fluoride in vitamins
- Bottled water
- Fluoride tablets/drops
- Well water
- Fluoridated water

DENTAL HISTORY

Child's first dental visit? Yes No

PREVIOUS DENTIST _____ CITY _____

DATE OF LAST VISIT _____

DATE OF LAST DENTAL X-RAYS _____

Any injuries to your child's teeth or jaws? Yes No
When? _____

History of:	When?
<input type="checkbox"/> Breast feeding	_____
<input type="checkbox"/> Bottle habits	_____
<input type="checkbox"/> Thumb sucking/finger sucking	_____
<input type="checkbox"/> Pacifier	_____
<input type="checkbox"/> Dental grinding or clenching	_____

Has your child experienced any unfavorable reaction from previous medical or dental care?

Yes No (If yes, please explain)

How do you think your child will act toward the dentist?

Has your child had recent dental pain?



CHILDREN'S DENTISTRY

Child's Name _____

MEDICAL HISTORY

Is your child presently under the care of your family physician for any medical reason? Yes No If yes, what? _____

DATE OF LAST PHYSICAL EXAM _____

FAMILY PHYSICIAN'S NAME _____

ADDRESS _____

PHONE NUMBER _____

Is your child presently under the care of a specialist for any medical reason? Yes No If yes, what? _____

SPECIALIST'S NAME _____

PHONE NUMBER _____

- Does your child have a history of health problems? Yes No
If yes, explain. _____
- Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt, or other medical reason? Yes No
- Is your child presently taking any medications? Yes No
What? _____
- Has your child had a history of taking medications frequently? Yes No
Which ones? _____
- Has your child ever been hospitalized or had surgery? Yes No
For what? _____
- Is your child allergic to a drug or drug product? Yes No
If yes, what? _____
- Is your child allergic to any medications? Yes No
If yes, what? _____
- Is your child allergic to any dyes or foods? Yes No
If yes, what? _____
- Is your child allergic to any environmental pollutants? Yes No
If yes, what? _____
- Is your child allergic to any metals (snaps)? Yes No
If yes, what? _____
- Is your child allergic to latex? Yes No
If yes, what? _____
- Has any member of the family, including your child, had a problem with a general anesthetic? Yes No

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK YES OR NO:

- | Y | N | | Y | N | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS-HIV | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding Problem |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Gagging |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma, If yes, what triggers it? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism | <input type="checkbox"/> | <input type="checkbox"/> | Growth & Developmental Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Conditions | <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusions | <input type="checkbox"/> | <input type="checkbox"/> | Hearing/Speech Impairments |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Defects | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur/Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone or Joint Problems | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain Injury | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruising Easily | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer or Malignancies | <input type="checkbox"/> | <input type="checkbox"/> | Hyperactivity/ADD |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy/Radiation | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Child Abuse | <input type="checkbox"/> | <input type="checkbox"/> | Mental Disability |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Adenoid/Tonsil Infection | <input type="checkbox"/> | <input type="checkbox"/> | Mouth sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Ear Infections | <input type="checkbox"/> | <input type="checkbox"/> | Nutritional Deficiency |
| <input type="checkbox"/> | <input type="checkbox"/> | Cleft Lip/Palate | <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Lesion | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Jaw Joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Premature Birth |
| <input type="checkbox"/> | <input type="checkbox"/> | Developmentally Disabled | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Addiction | <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear Stuffiness, Itching or Noises | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional Disturbance | <input type="checkbox"/> | <input type="checkbox"/> | Syndrome _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Problem | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wish to talk to the doctor privately about a special concern? | | | |

DENTAL INSURANCE

PRIMARY INSURANCE GROUP # _____

POLICY HOLDER NAME MEMBERSHIP # _____

SECONDARY INSURANCE GROUP # _____

POLICY HOLDER NAME MEMBERSHIP # _____



CHILDREN'S DENTISTRY

Child's Name _____

RESPONSIBLE PARTY

FATHER OR LEGAL GUARDIAN

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SS# _____ BIRTHDATE _____

HOME PHONE # _____ BUSINESS PHONE # _____

EMPLOYER _____ OCCUPATION _____

E-MAIL ADDRESS _____

MOTHER OR LEGAL GUARDIAN

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SS# _____ BIRTHDATE _____

HOME PHONE # _____ BUSINESS PHONE # _____

EMPLOYER _____ OCCUPATION _____

E-MAIL ADDRESS _____

NEAREST RELATIVE/FRIEND

NAME _____

ADDRESS _____ PHONE _____

RELATIONSHIP _____

ADDITIONAL FAMILY MEMBERS

NAME _____ BIRTHDATE _____

NAME _____ BIRTHDATE _____

NAME _____ BIRTHDATE _____

AUTHORIZATION

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. If my account requires servicing by a collection agency or by an attorney I understand that I will be liable for the collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to Children's Dentistry on any unpaid bills for services furnished me or my family. I authorize the release of any dental information necessary to process this claim and all future claims.

SIGNATURE _____

DATE _____

The permission of a parent or guardian is necessary for dental treatment of a minor:

I give the doctors permission to use such measures as deemed necessary in their professional judgement to render a diagnosis for my child. This would include an oral examination, radiographs (X-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions that my child's medical doctor has advised me should be reported to a dentist.

SIGNATURE _____

RELATIONSHIP TO CHILD _____

DATE _____

REVIEWED BY: DOCTOR _____

DATE _____