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
- ☐ Fluoride tablets/drops
- ☐ Fluoridated water
- ☐ Bottled water
- ☐ Well 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?
☐ Breast feeding	______________
☐ Bottle habits	______________
☐ Thumb sucking/finger sucking	______________
☐ Pacifier	______________
☐ 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
A PARTNERSHIP

5150 WEST 80TH AVENUE WESTMINSTER, COLORADO
303-427-1951 Toll Free 1-877-427-1951

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? If yes, explain.______________________________ ☐ Yes ☐ No
- 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? What?_________________________________ ☐ Yes ☐ No
- Has your child had a history of taking medications frequently? Which ones?___________________________ ☐ Yes ☐ No
- Has your child ever been hospitalized or had surgery? For what?_______________________________ ☐ Yes ☐ No
- Is your child allergic to a drug or drug product? If yes, what?___________________________ ☐ Yes ☐ No
- Is your child allergic to any medications? If yes, what?___________________________ ☐ Yes ☐ No
- Is your child allergic to any dyes or foods? If yes, what?___________________________ ☐ Yes ☐ No
- Is your child allergic to any environmental pollutants? If yes, what?___________________________ ☐ Yes ☐ No
- Is your child allergic to any metals (snaps)? If yes, what?___________________________ ☐ Yes ☐ No
- Is your child allergic to latex? If yes, what?___________________________ ☐ Yes ☐ No
- 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	Condition
☐	☐	AIDS-HIV
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Asthma, If yes, what triggers it? ____________________
☐	☐	Autism
☐	☐	Bladder Conditions
☐	☐	Blood Disease
☐	☐	Blood Transfusions
☐	☐	Birth Defects
☐	☐	Bone or Joint Problems
☐	☐	Brain Injury
☐	☐	Bruising Easily
☐	☐	Cancer or Malignancies
☐	☐	Cerebral Palsy
☐	☐	Chemotherapy/Radiation
☐	☐	Child Abuse
☐	☐	Chronic Adenoid/Tonsil Infection
☐	☐	Chronic Ear Infections
☐	☐	Cleft Lip/Palate
☐	☐	Congenital Heart Lesion
☐	☐	Convulsions/Seizures
☐	☐	Developmentally Disabled
☐	☐	Diabetes
☐	☐	Drug Addiction
☐	☐	Ear Stuffiness, Itching or Noises
☐	☐	Emotional Disturbance
☐	☐	Epilepsy
☐	☐	Eye Problem

Y	N	Condition
☐	☐	Excessive Bleeding Problem
☐	☐	Excessive Gagging
☐	☐	Fainting or Dizziness
☐	☐	Fever Blisters
☐	☐	Growth & Developmental Problems
☐	☐	Heart Surgery
☐	☐	Headaches
☐	☐	Hearing/Speech Impairments
☐	☐	Heart Murmur/Defect
☐	☐	Hemophilia
☐	☐	Hepatitis or Liver Disease
☐	☐	High Blood Pressure
☐	☐	Hyperactivity/ADD
☐	☐	Kidney Disease
☐	☐	Leukemia
☐	☐	Mental Disability
☐	☐	Mouth sores
☐	☐	Nutritional Deficiency
☐	☐	Orthopedic Problems
☐	☐	Pain in Jaw Joints
☐	☐	Premature Birth
☐	☐	Psychiatric Care
☐	☐	Rheumatic Fever
☐	☐	Scoliosis
☐	☐	Sickle Cell Anemia
☐	☐	Syndrome _____________
☐	☐	Tuberculosis
☐	☐	Other _______________

☐ ☐ 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 #

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Child's Name ___________________________

RESPONSIBLE PARTY

LEGAL GUARDIAN (relationship)

ADDRESS

CITY STATE ZIP

SS# BIRTHDATE

HOME PHONE # BUSINESS PHONE #

EMPLOYER OCCUPATION

E-MAIL ADDRESS

LEGAL GUARDIAN (relationship)

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 dianostic 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

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