WELCOME

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care and we strive to teach good oral care that will enable your child to have a beautiful smile that will last a lifetime. Thank you for filling out this form completely. If you have any questions at any time, please ask. We are happy to help.

ABOUT YOUR CHILD Date:_______________

Child's Name:____

Nickname:_____________________________________Birthdate:____/____/____Age:__________

Special interests, sports or hobbies:____

Child's address:____

City:________________________ Zip:____________ Home#:____________________________

Who may we thank for referring you?:____

Has your child been to the dentist before? Y N Last Visit:______________________________

Previous Dentist:____ Phone#:________________

ABOUT THE PARENTS Mom ☐ Dad ☐ is usually responsible for making the appointments

Mother's Name:____ Birthdate:____/____/____

Marital Status: S M W D SS#:_______________________________ DL#:_________________

Employer:____ WK#:_________________

Father's Name:____ Birthdate:____/____/____

Marital Status: S M W D SS#:_______________________________ DL#:_________________

Employer:____ WK#:_________________

PERSON RESPONSIBLE FOR ACCOUNT (If different from above)

Name:____ Phone#_________________

Relationship:_____________________________________ SS#:__________________________

Address:_____________________________________ City:_________________ Zip:____________

Employer:____ Wk#:_________________

PRIMARY DENTAL INSURANCE

Insurance Co. Name:______________________________________ Phone#:________________

Group#:________________ Insured's Employer:____

Insured's Name:____ Birthdate:___/___/____

S.S.#______________________ Relationship:____

SECONDARY DENTAL INSURANCE

Insurance Co. Name:______________________________________ Phone#:________________

Group#:________________ Insured's Employer:____

Insured's Name:____ Birthdate:___/___/___

S.S.#______________________ Relationship:____

MEDICAL HISTORY

Child's Physician:____ Phone#:_______________

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

Please Explain:____

Please list any medications your child is taking?____

Has your child ever had any of the following medical conditions?

Y N Heart Murmur
Y N Cancer
Y N Diabetes
Y N Rheumatic Fever
Y N HIV+ / AIDS
Y N Canker/ Cold Sores
Y N Congenital Heart Defects
Y N Convulsions / Epilepsy
Y N Tuberculosis
Y N Hemophilia
Y N Hepatitis / Liver Disease
Y N Asthma

Is your child allergic to any of the following drugs?

Y N Penicillin / Amoxicillin
Y N Erythromycin
Y N Dental Anesthetics
Y N Tetracycline
Y N Aspirin / Ibuprophin
Y N Codeine
Y N Other:____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

____

Signature of Parent or Guardian Date