For Children: Welcome To Our Practice

1) TELL US ABOUT YOUR CHILD

Today's Date:_____ DOB: _____
Child's Name: AGE: _____

_____
Last First MI

Nickname: _____ Male ❑ Female ❑
School: _____ Grade: _____
Home Phone #: _____
Child's Home Address:
Street_____ Apt. # _____
City _____ State ___ Zip _____

Other Family Members seen by us:

_____
_____
_____

Previous/Present Dentist: _____
_____

Street:_____
Phone #: _____ Last Visit: _____

Parent's Marital Status:
❑ Single ❑ Married ❑ Divorced

2) MOTHER'S INFORMATION

Name: _____
Wk #: _____ Ext: _____
Home#:_____
Employer: _____
DL #: _____
SS #: _____

FATHER'S INFORMATION

Name: _____
Wk #: _____ Ext: _____
Home#:_____
Employer: _____
DL #: _____
SS #: _____

3) PRIMARY DENTAL INSURANCE

Insurance Name:_____
Insurance Address: _____
_____
Insurance Co. Phone #: _____
Group/Policy: _____
Insured's Name: _____
Relationship to Patient: _____
Insured's DOB: _____
Insured's Employer: _____
SS #: _____
Orthodontic Coverage: ❑ Yes ❑ No

SECONDARY DENTAL INSURANCE

Insurance Name:_____
Insurance Address: _____
_____
Insurance Co. Phone #: _____
Group/Policy: _____
Insured's Name: _____
Relationship to Patient: _____
Insured's DOB: _____
Insured's Employer: _____
SS #: _____
Orthodontic Coverage: ❑ Yes ❑ No

Continued on the next page.....

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA and the ADA.

4) Why did you bring the child to the orthodontist today?

Has the child ever had a serious/difficult problem associated with dental work? ❑ Yes ❑ No

Is the child's water flouridated? ❑ Yes ❑ No

Is the child taking flouridated supplements? ❑ Yes ❑ No

Has the child ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Does the child brush teeth daily? ❑ Yes ❑ No

Floss their teeth daily? ❑ Yes ❑ No

Child's Physician: _____

Phone #: _____ Last Visit_____

Is the child currently under the care of a physician? ❑ Yes ❑ No

Please describe the child's health:

❑ Good ❑ Fair ❑ Poor

Please list all of the drugs the child is currently taking:

_____

_____

Please list all the drugs the child is allergic to:

_____

_____

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

❑Yes	❑ No	Heart Murm	❑Yes	❑ No	Congenital Heart Def
❑Yes	❑ No	Cancer	❑Yes	❑ No	Convulsions/Epilepsy
❑Yes	❑ No	Diabetes	❑Yes	❑ No	Abnormal Bleeding
❑Yes	❑ No	Rheum. Fever	❑Yes	❑ No	Hearing Impairment
❑Yes	❑ No	HIV+/AIDS	❑Yes	❑ No	Any Operations
❑Yes	❑ No	Hemophilia	❑Yes	❑ No	Any Stays in Hospital
❑Yes	❑ No	Asthma	❑Yes	❑ No	Kidney/Liver Problems
❑Yes	❑ No	Hepatitis	❑Yes	❑ No	Handicaps/Disabilities
❑Yes	❑ No	Tuberculosis	❑Yes	❑ No	Allergies to Any Drugs
❑Yes	❑ No	Prosthesis	❑Yes	❑ No	History of Scarlet Fever

Please discuss any serious medical problems that the child has had:

_____

_____

_____

6) Does the child have any of the following habits?

❑Yes ❑ No Thumb Sucking / Finger Sucking

❑Yes ❑ No Lip Sucking / Biting

❑Yes ❑ No Nail Biting

❑Yes ❑ No Nursing Bottle Habits

7) I understand the information 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 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 the time of service unless prior arrangements have been approved.

OFFICE USE ONLY - 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: _____