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. We strive to teach good oral health that will enable your child to have a beautiful smile that lasts a lifetime.

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

1 ABOUT YOUR CHILD

Name: ______________________
LAST FIRST INITIAL

Preferred Name: ______________ Age: ______

Birthdate: ______________ ❑ Male ❑ Female
MONTH DAY YEAR

IS COMMUNICATION ASSISTANCE NEEDED? ❑ Yes ❑ No

IF YES, PREFERRED LANGUAGE: ______________

Names and ages of brothers and sisters: ______________

Special interests, sports, or hobbies: ______________

School: ______________ Grade: ______

Child lives with: ❑ Mother ❑ Father ❑ Both ❑ Other

HOME PHONE: ______________

Mailing address: ______________

APT./CONDO # CITY STATE ZIP CODE

2 ABOUT YOU

FATHER'S NAME: ______________

Cell phone: ______________

Email: ______________

Employer: ______________

Social Security Number: ______________

Work phone: ______________ Ext. ______

MOTHER'S NAME: ______________

Cell phone: ______________

Email: ______________

Employer: ______________

Social Security Number: ______________

Work phone: ______________ Ext. ______

OTHER GUARDIAN'S NAME: ______________

Relationship to Child ______________

Cell phone: ______________

Email: ______________

Employer: ______________

Social Security Number: ______________

Work phone: ______________ Ext. ______

HOW DID YOU HEAR ABOUT OUR OFFICE? Check all that apply:

❑ Doctor (NAME) ______________

❑ Friend/Relative (NAME) ______________

❑ School (NAME) ______________

❑ Insurance Co. (NAME) ______________

❑ Ledger ❑ Google ❑ Social Media ❑ Office Pamphlet

❑ Other ______________

3 EMERGENCY CONTACT

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name: ______________

Relationship: ______________ Phone: ______________

NEAREST FRIEND OR RELATIVE NOT LIVING WITH PATIENT:

Name: ______________ Phone: ______________

4 PRIMARY INSURANCE

Dental Ins. Co.: ______________

Insurance Co. phone #: ______________

Group #: ______________ ID#: ______________

Employee name: ______________

Marital status: ❑ Married ❑ Single ❑ Divorced

Relationship to child: ______________

Employee: ______________ ______________
SOCIAL SECURITY NUMBER BIRTHDATE

Employer: ______________

5 SECONDARY INSURANCE

Dental Ins. Co.: ______________

Insurance Co. phone #: ______________

Group #: ______________ ID#: ______________

Employee name: ______________

Marital status: ❑ Married ❑ Single ❑ Divorced

Relationship to child: ______________

Employee: ______________ ______________
SOCIAL SECURITY NUMBER BIRTHDATE

Employer: ______________

PLEASE TURN TO COMPLETE

6 DENTAL/MEDICAL HISTORY

Who is your family dentist? ______________________

Has your child been to the dentist before? ❑ Yes ❑ No

If yes, the approximate date of last visit: ______________________

Has your child been seen in a dental or sealant program at school or dental bus? ❑ Yes ❑ No

Are there any dental problems that you are aware of at present? ❑ Yes ❑ No

If yes, please explain: ______________________

____

Has your child had trauma to the head, face or teeth? ❑ Yes ❑ No

If yes, please explain: ______________________

____

Does your child brush his/her teeth daily? ❑ Yes ❑ No

Is there a history of oral habits (thumb sucking, lip or nail biting)? ❑ Yes ❑ No

Please rate your child's oral health: ❑ Good ❑ Fair ❑ Poor

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

Child's physician: ______________________

The approximate date of last visit: ______________________

Has your child ever had a serious illness or operation? ❑ Yes ❑ No

If yes, please explain: ______________________

____

Please rate your child's medical health: ❑ Good ❑ Fair ❑ Poor

Does your child have allergies or any unfavorable reaction to any medicine such as: Penicillin, Aspirin, Demerol, Local Anesthesia, Acetaminophen, Codeine, or Ibuprofen? ❑ Yes ❑ No

If yes, please explain: ______________________

Is your child taking any prescription drugs? ❑ Yes ❑ No

If yes, please list: ______________________

What condition(s) is this medication for: ______________________

____

7 HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

PLEASE CIRCLE

- Y N Premature birth/Birth defects
- Y N Genetic conditions/Syndromes
- Y N Congenital heart disease/Murmur
- Y N Irregular heart beat/High blood pressure
- Y N Asthma/Reactive airway disease/Bronchitis
- Y N Sleep apnea/Snoring
- Y N Cystic Fibrosis
- Y N Pneumonia/Tuberculosis
- Y N Seizures/Epilepsy/Convulsions
- Y N Cerebral palsy
- Y N Autism/Autism spectrum disorder/Asperger's
- Y N Kidney/Bladder problems
- Y N Liver problems/Hepatitis
- Y N Gastric reflux (GERD)/Intestinal problems
- Y N Crohn's disease/Celiac disease
- Y N Diabetes
- Y N Thyroid/Pituitary problems
- Y N Anemia/Sickle cell disease or trait
- Y N Hemophilia/Other bleeding disorders
- Y N HIV or AIDS/Hepatitis B, STD
- Y N Cancer/Chemotherapy/Radiation therapy
- Y N ADHD/ADD/ODD
- Y N Psychiatric problems
- Y N Surgeries/Stays in hospital
- Y N Is your child pregnant
- Y N Other problems not listed here

If yes, please specify:

____

____

____

____

AUTHORIZATION

I certify that the information provided on this form (front and back) is true and accurate. I acknowledge that it is my responsibility to inform this office of any future changes in medical history. I understand that a legal guardian or person who has been granted power of attorney must accompany the child to all dental appointments. I authorize the dental staff at this office to perform the necessary dental services that my child may need.

I will make every effort to ensure my child arrives promptly at the scheduled appointment time. I fully understand the parent or guardian who accompanies the child to each appointment is responsible for payment at the time of services unless prior arrangements have been approved.

Parent/Guardian: ______________________
(Print Name)

Parent/Guardian: ______________________ Date: ______________
(Signature)

REMEMBER ... HEALTHY TEETH ARE HAPPY TEETH!