We are pleased to welcome you and your family to our practice. Please take a few minutes to fill out this form completely.
If you have questions we'll be glad to help you.
We look forward to working with your child.

Child's name ______________________________
Last Name First Name Initial

Address ______________________________

City ____________ State ________ Zip ________ Home Phone ____________

Family Email ______________________________

Sex ❑ M ❑ F Birth date ____________ School ______________________________

Grade ____________ Hobbies/Sports ______________________________

How were you referred to our office? ______________________________

Notify in case of emergency ______________________________

Business phone ____________ Cell Phone ____________ Email ____________

Primary Dental Insurance

Person responsible for the Account ______________________________
Last Name First Name Initial

Relationship to Child ____________ Birth date ____________ Soc. Sec. # ____________

Address (if different from child) ______________________________

City ____________ State ________ Zip ________ Home Phone ____________

Cell Phone ____________ Email ______________________________

Person Responsible Employed by ____________ Occupation ____________

Business Address ______________________________ Business Phone ____________

Business Email ______________________________

Insurance Company ______________________________ Phone ____________

Contract # ____________ Group # ____________ Subscriber ID # ____________

Name of other dependents under this plan ______________________________

Additional Dental Insurance

Is child covered by additional dental insurance? ❑ Yes ❑ No

Subscriber Name ____________ Relation to Child ____________ Birth date ____________

Address (if different from child) ______________________________ Soc. Sec. # ____________

City ____________ State ________ Zip ________ Home Phone ____________

Cell Phone ____________ Email ______________________________

Subscriber Employed by ______________________________ Business Phone ____________

Business Email ____________ Insurance Email ____________

Insurance Company ______________________________ Phone ____________

Contract # ____________ Group # ____________ Subscriber ID # ____________

Name of other dependents under this plan ______________________________

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Dental History

What would you like us to do for your child today? ______________________________

____

Former Dentist ______________________________ Address ______________________________

Dentist's Email ______________________________ Phone ______________________________

Date of last dental visit ______________________________ Date of last X-rays ______________________________

How often does your child brush? ______________________________Floss ______________________________

Does your child experience pain or discomfort in the jaw joint? ❑ Yes ❑ No

Has your child ever experienced a mouth or chin injury? ❑ Yes ❑ No

Does your child have speech problems? ❑ Yes ❑ No

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

❑ Yes ❑ No

Child's habits affecting the mouth or teeth: ❑ Thumb sucking ❑ Nail biting ❑ other ______________________________

Other information about your child's dental health or previous treatment ______________________________

____

Medical History

Child's Physician ______________________________ Phone ______________________________

Physician Email ______________________________

Date of last visit ____________ has your child had any serious illness or operations? ☐ Yes ☐No

If yes, describe ______________________________

Is your child currently under physician care ❑ Yes ❑ No if yes, describe ______________________________

Has your child ever had a blood transfusion? ❑ Yes ❑ No if yes, give approximate dates ______________________________

Has your child ever taken Fen-Phen/Redux? ❑ Yes ❑ No

Has your child ever had or currently have:

❑ Yes ❑ No ADHD
❑ Yes ❑ No ADD/BD
❑ Yes ❑ No AIDS/HIV Positive
❑ Yes ❑ No Anemia
❑ Yes ❑ No Asperger Syndrome
❑ Yes ❑ No Asthma
❑ Yes ❑ No Atopic (allergy prone)
❑ Yes ❑ No Autism
❑ Yes ❑ No Bi Polar
❑ Yes ❑ No Cancer
❑ Yes ❑ No Cerebral Palsy
❑ Yes ❑ No Chicken Pox
❑ Yes ❑ No Convulsions/Epilepsy
❑ Yes ❑ No Cough, persistent
❑ Yes ❑ No Cough up blood
❑ Yes ❑ No Diabetes

❑ Yes ❑ No Down Syndrome
❑ Yes ❑ No Epilepsy
❑ Yes ❑ No Fainting
❑ Yes ❑ No Food allergies
❑ Yes ❑ No Headaches
❑ Yes ❑ No Hearing Impaired
❑ Yes ❑ No Heart problems
Describe ______________________________
____
❑ Yes ❑ No Hemophilia/ Abnormal bleeding
❑ Yes ❑ No Immunizations Current
❑ Yes ❑ No Kidney disease or Malfunction
❑ Yes ❑ No Liver disease

❑ Yes ❑ No Material Allergies (**latex**, wool, metal, chemicals)
❑ Yes ❑ No Respiratory disease
❑ Yes ❑ No Rheumatic/Scarlet fever
❑ Yes ❑ No Sensory integration disorder
❑ Yes ❑ No Shortness of breath
❑ Yes ❑ No Skin rash
❑ Yes ❑ No Speech Impairment disorder
❑ Yes ❑ No Spina Bifida
❑ Yes ❑ No Thyroid disease or Malfunction
❑ Yes ❑ No Tonsillitis
❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Other
Describe ______________________________
____

List medications your child is taking, if any:

____

____

List drug allergies, if any:

____

____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist.
I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered, I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: ______________________________ Date ______________

Payment is due in full at the time of treatment, unless prior arrangements have been approved.