

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. We strive to teach good oral care
 that will enable your child to enjoy the magic of a beautiful smile!

ABOUT YOUR CHILD



Name: _____
Last First Middle Initial

Birthday: _____
Month Day Year Male Female

Nickname: _____

Social Security#: _____

Home Phone: _____

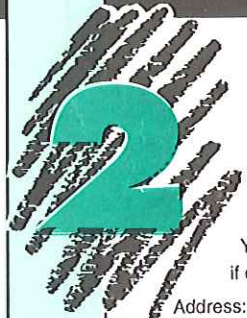
Home Address: _____
Apt./Condo# City State Zip Code

School - Town _____

College - Full or Part-time _____

Referred by: _____

ABOUT YOU



Name: _____

Social Security#: _____

Driver's License # _____

Relationship to child: _____

Your home phone and address,
 if different from child's: _____
 Address: _____

Birthday: _____
 Married Single Divorced Widow Head of House

Employer: _____

Address & Town: _____

Work phone: _____ Ext. _____

Beeper/Car phone: _____

Send Statement To: _____

DENTAL INSURANCE COMPANY #1



Dental insurance Co. #1 _____

Address & Town: _____

Their phone# _____

Group # _____

This Dental Insurance is provided through: _____

Their Employer's Name: _____

Address & Town: _____

Name of Insured: _____

Their Relationship to child: _____

Their Social Security# _____

Their Birthdate: _____
Month Day Year

DENTAL INSURANCE COMPANY #2

Dental insurance Co. #2 _____

Address & Town: _____

Their phone# _____

Their Group # _____

This Dental Insurance is provided through: _____

Their Employer's Name: _____

Address & Town: _____

Name of Insured: _____

Their Relationship to child: _____

Their Social Security# _____

Their Birthdate: _____
Month Day Year

Our Office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA.
(PLEASE COMPLETE OTHER SIDE)

DENTAL/MEDICAL HISTORY

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

If yes, the approximate date of last visit: _____

Are there any dental problems that you are aware of present?:

Yes No If yes, please explain: _____

Does your child brush his/her teeth daily? 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: _____

Their phone #: _____

The approximate date last visit: _____

Is your child allergic to any drugs? Yes No

If yes, please list: _____

Is your child taking any prescription drugs? Yes No

If yes, please list: _____

Does your child need to be premedicated before dental treatment?

Yes No

6 In the event of an emergency, who should we contact?

Name _____

Relationship _____

Phone _____

Phone #2 _____

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

Please Circle.

- Y N Heart Murmur/Rheumatic Fever
- Y N Heart problems of any kind.
- Y N Convulsions/Epilepsy
- Y N Cancer
- Y N Diabetes
- Y N Rheumatic Fever
- Y N HIV+/AIDS/ARC
- Y N Hemophilia
- Y N Bleeding problems of any kind
- Y N Hearing Impairment
- Y N Hyperactive
- Y N Any Operations
- Y N Any stays in Hospital.

Are there any other medical conditions or problems relating to your child?

Yes No If yes, please list:

I understand that the information that I have given is correct to the best of my knowledge, that it 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. I also authorize the dental staff to perform the necessary dental services my child may need.

The parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved. A fee of 1.5% will be charge to accounts 60 days past due.

Signature of parent or guardian

Date

Thank you for filling out this form completely. It will enable us to give your child the best dental care possible. If you or your child have any questions, please feel free to ask us at any time.