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!

1 ABOUT YOUR CHILD

Name: ______________________
Last First Middle Initial

Birthday: ______________ ☐ Male ☐ Female
Month Day Year

Nickname: ______________________

Social Security#: ______________________

Home Phone: ______________________

Home Address: ______________________

____
Apt./Condo# City State Zip Code

School - Town ______________________

College - Full or Part-time ______________________

Reffered by: ______________________

2 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: ______________________

3 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 at 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

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:

____

____

6

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

Name ____________

Relationship ____________

Phone ____________

Phone #2 ____________

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.