Patient Information

TELL US ABOUT YOUR CHILD... Today's Date ___/___/_____

Child's Name_____ Preferred Name (if different)_____ ❑Male ❑Female

Address_____City_____State_____Zip_____

Date of Birth ____/_____/_____ Age_____ Weight_____ Preferred Phone (_____)_____-_____

Previous/Present Dentist_____ Last Visit Date_____

Why did you bring your child to the dentist today?_____

Whom may we thank for referring you to our office?_____

Child's Health History

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

Is the child's water fluoridated? ❑Yes ❑No Is the child taking fluoride supplements? ❑Yes ❑No

Does the child brush his/her teeth daily? ❑Yes ❑No Floss Daily? ❑Yes ❑No

Does the child have any of the following habits?

Y Lip Sucking/Biting Y Nail Biting

Y Nursing/Bottle Habits Y Thumb/Finger Sucking

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y Abnormal Bleeding	Y Convulsions/Epilepsy	Y Hemophilia
Y Allergies to any drugs*	Y Diabetes	Y Hepatitis
Y Any Hospital Stays/Operations**	Y Echocardiogram	Y HIV+/AIDS
Y Asthma	Y Fainting	Y Kidney/Liver Problems
Y Autism/Aspergers	Y Handicaps	Y Latex Allergy
Y Cancer	Y Hearing Impairment	Y Rheumatic/Scarlet Fever
Y Congenital Heart Defect	Y Heart Murmur	Y Tuberculosis (TB)

*Please list all drugs that the child is ALLERGIC to_____

**Please explain any hospital stays/operations_____

Please list all drugs that the child is currently taking_____

Has the child had any serious medical problems? ❑Yes ❑No If yes, explain_____

_____

Child's Pediatrician/Physician_____ Phone_____ Last Visit _____

Person to contact in case of Emergency <u>Outside</u> of Immediate Family Household

Name_____ Phone_____

Parent/Guardian Information

Parent's Marital Status ❑Married ❑Separated ❑Divorced ❑Widowed ❑Single

Mother's Name_____ ❑Mother ❑Guardian Birth Date ____/____/____

Address (if different than patient)_____ City_____ State_____ Zip_____

Mobile #_____ Home #_____ Work #_____ Ext____

Employer_____ SS#_____ DL#_____

Father's Name_____ ❑Father ❑Guardian Birth Date ____/____/____

Address (if different than patient)_____ City_____ State_____ Zip_____

Mobile #_____ Home #_____ Work #_____ Ext____

Employer_____ SS#_____ DL#_____

****We offer reminder emails and/or text messages****

Please select how you would like reminders and fill out the following information

❑Text & Email ❑Text Only ❑Email Only ❑Opt-Out

to Receive Texts_____ Email Address_____

****If there is any situation in which we are unable to reach you through text or email, you are still responsible for your appointment!****

Insurance Information

FILL OUT THIS ENTIRE SECTION EVEN IF WE HAVE MADE COPIES OF YOUR CARDS

PRIMARY DENTAL INSURANCE

Insurance Co_____

Address_____

_____

Phone_____ Group #_____

Policy #_____

Insured's Name_____

Insured's Employer_____

Do you have orthodontic coverage? ❑Yes ❑No

SECONDARY DENTAL INSURANCE

Insurance Co_____

Address_____

_____

Phone_____ Group #_____

Policy #_____

Insured's Name_____

Insured's Employer_____

Do you have orthodontic coverage? ❑Yes ❑No

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 authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent Date

*****UPDATE (to be completed later) I have reviewed and update all information on this form*****

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____