



Welcome Forms

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 proper oral health care that will enable your child to have a beautiful smile that lasts a lifetime. The information requested below is very important and becomes part of our permanent records. Please make sure your answers are as complete and accurate as possible.

Tell Us About Your Child:

Today's Date: _____

Name: _____

Nickname: _____

Birth Date: _____

Age: _____ Gender: Male / Female

Home Address: _____

School: _____ Grade: _____

Name/Age of Siblings: _____

Siblings Seen by Us That Child Lives With?

Adopted? Y / N

Who can we thank for referring you?

Health History

Child's Physician: _____ Phone: (_____)_____

Date of last visit: _____ Address: _____

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

Please explain: _____

Please describe your child's current physical health: Good Fair Poor

Are Immunizations Current? Yes No

Please list all medications and dosage that your child is currently taking:

Please list all drugs and/or things that cause your child allergic reactions:

Has your child had/experienced any of the following: (please circle)

Y	N	Abnormal Bleeding	Y	N	Endocrine System Disorders	Y	N	Mitral Valve Prolapse
Y	N	AIDS/HIV+	Y	N	Epilepsy	Y	N	Mononucleosis
Y	N	Allergies	Y	N	Frequent Infections	Y	N	Rheumatic Fever
Y	N	Anemia	Y	N	Handicaps: _____	Y	N	Recurrent Headaches
Y	N	Any Hospital Stays						Frequency: _____
Y	N	Any Operations	Y	N	Hearing Impaired	Y	N	Scarlet Fever
Y	N	Asthma	Y	N	Heart Murmur	Y	N	Seizures
Y	N	Behavior/Learning/Disabilities	Y	N	Hemophilia	Y	N	Sickle Cell Anemia
Y	N	Blood Dyscrasis	Y	N	Hepatitis	Y	N	Sight Disorders
Y	N	Blood Transfusion	Y	N	High Blood Pressure	Y	N	Significant Injuries
		Date: _____	Y	N	Hives			List: _____
Y	N	Breathing/Lung Problems	Y	N	Kidney Problems			_____
Y	N	Cancer/Tumors	Y	N	Liver/CI System Problems			_____
Y	N	Chicken Pox	Y	N	Low Blood Pressure	Y	N	Skin Rash
Y	N	Congenital Birth Defect	Y	N	Lupus	Y	N	Tonsilitis
Y	N	Congenital Birth Disease	Y	N	Measles	Y	N	Tuberculosis (TB)
Y	N	Diabetes	Y	N	Mentally Physically Disabled			

1. Has your child ever been hospitalized? Yes No

If so, when? _____ For what reason? _____

2. Has your child had any operations? Yes No

If so, when? _____ For what reason? _____

Was general anesthesia used? Yes No

Any complications, if so, what? _____

3. Does your child bruise easily? Yes No

4. Has there ever been any history of spontaneous bleeding (e.g., nose bleeds) or prolonged bleeding following tooth removal surgery, cuts, etc.? Yes No

REMARKS:

Dental History

1. Please check reason(s) for seeking dental care

First Examination

Routine check-up

Toothache or swelling

Other _____

Appearance of teeth or face

Crowding Teeth

Accident

2. If your child has been to a dentist previously? Yes No

a. When was the last visit? _____

b. Have x-rays been taken and when? Yes No Date _____

c. How would you describe your child's temperament? _____

3. How do you think your child would react to dental treatment? _____

4. Has your child had fluoride in any of the following forms?

Fluoride tablets or in vitamins (Fluoride amt. .25 .5 1.0 mg) Yes No

Drinking water (community fluoridation) Yes No

Topical application to teeth? Yes No When is last _____

Toothpaste; brand _____

5. Does your child brush his/her own teeth? Yes No

How frequently and when? A.M. P.M. After Snacks Before Bed After Breakfast

6. Do you brush your child's teeth? Yes No

How frequently and when? A.M. P.M. After Snacks Before Bed After Breakfast

7. Do you or your child use dental floss in cleaning your child's teeth? Yes No

How frequently and when? A.M. P.M. After Snacks Before Bed After Breakfast

8. Does your child have between meal snacks Yes No

9. Have your child's teeth ever been injured?

When? _____ Which teeth? _____

Cause? _____

Were the teeth treated? Yes No

If so, describe treatment _____

10. Does your child have any of the following habits? (Indicate ages when occurred)

Bottle to bed at night _____

Thumb or finger sucking _____

Pacifier _____

Tongue thrusting _____

Lip sucking or biting _____

Breathes through mouth _____

11. Has your child received any unusual dental or surgical treatment to the mouth? Yes No

If so, what _____

Guarantor Information

FATHER'S INFORMATION

Name: _____
Address: _____
Home Phone: _____
Relationship to Patient: _____
Birthday: _____
Social Security Number: _____
Occupation: _____
Employer: _____
Address: _____
Work Phone: (____) _____

Insurance Company Name: _____
Name of Policy Holder: _____
Insurance Company Address: _____
Insurance Company Phone: _____
Group or Plan Number: _____

MOTHER'S INFORMATION

Name: _____
Address: _____
Home Phone: _____
Relationship to Patient: _____
Birthday: _____
Social Security Number: _____
Occupation: _____
Employer: _____
Address: _____
Work Phone: (____) _____

Insurance Company Name: _____
Name of Policy Holder: _____
Insurance Company Address: _____
Insurance Company Phone: _____
Group or Plan Number: _____

In order to control the cost of dental services, we require that payment be made at the time of service, unless otherwise discussed previously with our Financial Coordinator. Payment can be made with cash, personal check, MasterCard or Visa. If for any reason your check is returned to us, there will be an additional fee.

Please indicate the person responsible for payment fees:

Name: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: (____) _____

Employer: _____
Work Phone #: (____) _____
Relationship to Patient: _____

CONSENT FOR TREATMENT

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental 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. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf.

Authorization & Release

Signature of Parents/Guardian _____ Date _____