

# WELCOME KIDS

We would like to welcome 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 have a beautiful smile that lasts a lifetime!

## 1 Tell Us About Your Child

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Last First MI

Child's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age: \_\_\_\_\_

Nickname: \_\_\_\_\_ ☐ Male ☐ Female

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Child's Home #: (\_\_\_\_) \_\_\_\_\_ SS #: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

Apt / Condo #

City

State

Zip

## 2 General Information

Who is accompanying the child today?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? \_\_\_\_\_

Other siblings: \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_ Last Visit Date \_\_\_\_\_

Dentist's Phone #: (\_\_\_\_) \_\_\_\_\_

Relative or Friend not living with you:

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City

State

Zip

## 3 Parent's Information

Person Responsible for Account: \_\_\_\_\_ Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorce ☐ Separated

☐ Father ☐ Step Father ☐ Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: (If different than Child's) Hm #: (\_\_\_\_) \_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Cell/Other #: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City

State

Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City

State

Zip

Insurance Phone: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

☐ Mother ☐ Step Mother ☐ Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: (If different than Child's) Hm #: (\_\_\_\_) \_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Cell/Other #: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City

State

Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City

State

Zip

Insurance Phone: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

## 4 Release

I certify that my child is covered by \_\_\_\_\_ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian

Date

USA

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## Dental History



## Medical History

Why did you bring the child to the dentist today? \_\_\_\_\_

Has the child ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Has your child ever taken Phen-Fen? ☐ Yes ☐ No

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

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 fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

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

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

Please list all drugs that the child is currently taking:

Aside from the items below, please list all drugs/things that the child is allergic to:

Yes No Latex      Yes No Metals/Nickel      Yes No Plastic

Has the child experienced the following medical problems?

Y N Abnormal Bleeding / Hemophilia	Y N Heart Murmur
Y N ADD/ADHD	Y N Hepatitis
Y N AIDS/HIV+	Y N High Blood Pressure
Y N Anemia	Y N Hives
Y N Any Hospital Stays/Operations?	Y N Kidney Problems
Y N Artificial Bones/Joints/Valves	Y N Liver Problems
Y N Asthma	Y N Low Blood Pressure
Y N Cancer	Y N Lupus
Y N Chicken Pox	Y N Measles
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Convulsions	Y N Mononucleosis
Y N Diabetes	Y N Prosthetics
Y N Epilepsy	Y N Rheumatic Fever
Y N Exposed to HIV, but Neg.	Y N Scarlet Fever
Y N Handicaps/Disabilities	Y N Skin Rash
Y N Hearing Impairment	Y N Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experiences/ed:

Does/did the child experience any of the following?

Y N Breast Fed	Y N Nursing Bottle Habits
Y N Chewing on Objects	Y N Speech Problems
Y N Clenching/Grinding Teeth	Y N Thumb/Finger Sucking
Y N Lip Sucking/Biting	Y N Tongue/Cheek Biting
Y N Mouth Breather	Y N Tongue Thrust
Y N Nail Biting	Y N Used Pacifier

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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 or Guardian

Date

OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Signature of Dentist

Date

Dentist's Comments: \_\_\_\_\_

## Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. \_\_\_\_\_

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. \_\_\_\_\_

Parent/Guardian Signature

Date

Dentist Signature

Date

Parent/Guardian Signature

Date

Dentist Signature

Date