1. TELL US ABOUT YOUR CHILD. **PLEASE COMPLETE ALL INFORMATION.**

Child's Name _____ (LAST / FIRST / MI)

Nickname _____ Child's Birthdate _____ Age _____ Sex _____

Address _____ (Street / City / State / Zip)

Preferred Language _____ Race _____ Ethnicity _____ (Patient)

2. PARENTS INFORMATION.

Mothers Name _____ Phone# _____ Cell# _____

Home Address _____ E-Mail _____ (Street / City / State / Zip)

Driver's License # _____ Marital Status _____

Employer _____ Work Phone # _____

Employer Address _____

Mother's Birth Date _____ Mothers Social Security # _____

Fathers Name _____ Phone _____ Cell# _____

Home Address _____ E-Mail _____ (Street / City / State / Zip)

Drivers Licence # _____ Marital Status _____

Employer _____ Work Phone # _____

Employer Address _____

3. Fathers Birth Date _____ Fathers Social Security # _____

WHOM IS ACCOMPANYING THE CHILD TODAY ?

Name _____ Relationship _____

Whom is responsible for making appointments. Name _____

Work Phone # _____ Home Phone # _____

4. INSURANCE INFORMATION

We are happy to file your insurance claim for you, However, we do not determine the amount of coverage you will receive, this is done by your insurance company. Any remaining balance or uncovered service is the responsibility of the parent/ guardian. Any questions concerning your insurance benefits should be directed to your insurance representative.

Primary Insurance Co. _____ (NAME / GROUP POLICY OR ID # / SUBSCRIBER)

Secondary Insurance Co. _____ (NAME / GROUP POLICY OR ID # / SUBSCRIBER)

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTISTS OF CHILDREN'S DENTISTRY LTD. OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME

_____ (SIGNATURE (INSURED PERSON))

THe policy in our office is the Parent or guardian who accompanies the child and requests treatment is responsible for payment of all fees at the time of service unless prior arrangements have been approved. In case of default of this account, I agree to pay collection costs on the outstanding balance.

_____ Date _____

SIGNATURE OF PARENT OR CUARDIAN REQUESTING CARE.

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

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____

DENTAL HISTORY

CHILD'S FIRST DENTAL VISIT? ☐ YES ☐ NO	PREVIOUS DENTIST	CITY	DATE LAST VISIT	X-RAY DATE

ANY INJURY TO YOUR CHILD'S TEETH OR JAWS? (FALLS, BLOWS, CHIPS, ETC.) ☐ YES ☐ NO

HISTORY OF? ☐ THUMBSUCKING ☐ LIP SUCKING ☐ GINGIVITIS ☐ FINGER SUCKING ☐ NAIL BITING ☐ PACIFIER

HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL OR DENTAL CARE? ☐ YES ☐ NO

EXPLAIN

HOW DO YOU THINK YOUR CHILD WILL ACT TOWARD THE DENTIST?

AGE OF CHILD WHEN DISCONTINUED BOTTLE OR NURSING

NAME OF FAMILY DENTIST

CITY

PREVENTIVE DENTAL HISTORY

HOW OFTEN DOES YOUR CHILD BRUSH?	IS TOOTHBRUSHING SUPERVISED? ☐ YES ☐ NO	BY WHOM?	WHEN?

IS DENTAL FLOSS USED? ☐ YES ☐ NO

DOES YOUR CHILD RECEIVE (CHECK). ☐ FLUORIDE IN VITAMINS ☐ FLUORIDE TABLETS/DROPS ☐ FLUORIDATED WATER ☐ NONE ☐ HOW OFTEN?

MEDICAL HISTORY

CHILD'S PHYSICIAN

DATE LAST SAW PHYSICIAN _____ MONTH/YEAR

	YES	NO
1. IS YOUR CHILD PRESENTLY UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL PROBLEM? WHAT?	☐	☐
2. IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION? WHAT?	☐	☐
3. HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? FOR WHAT?	☐	☐
4. IS YOUR CHILD ALLERGIC TO ANY FOOD OR MEDICINE? WHAT?	☐	☐
5. IS YOUR CHILD PREGNANT?	☐	☐

DOES YOUR CHILD HAVE A HISTORY OF? (CHECK YES OR NO)

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	HEART MURMURS	☐	☐	HEARING PROBLEMS	☐	☐	CANCER/TUMORS	☐	☐	LEUKEMIA
☐	☐	HEART TROUBLE	☐	☐	DIABETES	☐	☐	MENTAL RETARDATION	☐	☐	HEPATITIS
☐	☐	RHEUMATIC FEVER	☐	☐	ASTHMA	☐	☐	CONGENITAL BIRTH DEFECTS	☐	☐	BLEEDING PROBLEMS
☐	☐	ALLERGIES	☐	☐	EPILEPSY	☐	☐	SPEECH PROBLEMS	☐	☐	BLOOD DISORDERS
☐	☐	ANESTHESIA-ALLERGIC/SENSITIVE	☐	☐	SEIZURES/CONVULSIONS	☐	☐	ANEMIA	☐	☐	HIGH BLOOD PRESSURE
☐	☐	DRUG SENSITIVITIES	☐	☐	RECURRENT HEADACHES	☐	☐	LEARNING DISABILITIES	☐	☐	RADIATION TREATMENT
☐	☐	HIGH TEMPERATURE	☐	☐	FRACTURED JAW	☐	☐	BEHAVIORAL PROBLEMS	☐	☐	HISTORY OF BLOOD TRANSFUSIONS & DATE
☐	☐	BRAIN INJURY	☐	☐	LUNG TROUBLE/T.B.	☐	☐	AIDS/ARC/HIV			
☐	☐	VISION PROBLEMS	☐	☐	ARTIFICIAL PROSTHESIS	☐	☐	KIDNEY/LIVER INVOLVEMENT			
☐	☐	USE TOBACCO PRODUCTS	☐	☐	MALARIA	☐	☐	AUTOIMMUNE DISEASE	☐	☐	PREGNANT (IF APPLICABLE)
						☐	☐	CHRONIC ILLNESS	☐	☐	AUTISM

Is there anything else regarding your child's Physical, mental or EMOTIONAL health that you feel we should know. What?