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

Who is responsible for account? ________ Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ 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

Continued on Back

Dental History

Why did you bring the child to the dentist today? ______________________

____

____

Has the child ever taken any diet pills such as Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin.) If so, when? ______________________

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 prescription / over the counter or herbal supplement 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

Medical History

Has the child experienced the following medical problems?

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

____

____

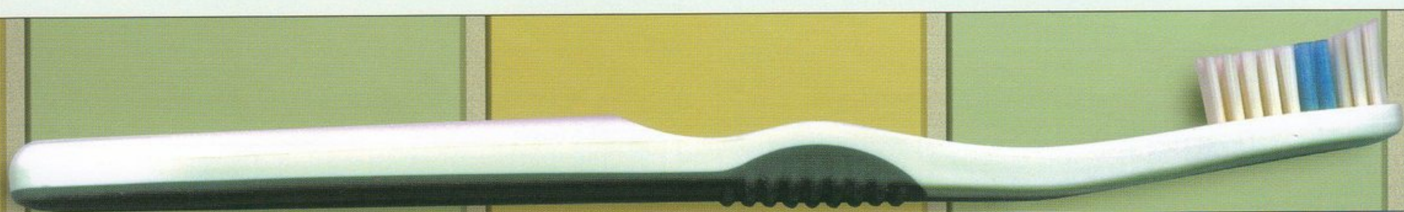
Does/did the child experience any of the following?

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



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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

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