Welcome

We would like to welcome you and your child to our office. We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep the smile beautiful for their lifetime.

TELL US ABOUT YOUR CHILD Today's Date ______________

Child's Name: ______________ Child's Birthdate: ____/____/____ Child's Age: ________

Nickname: ______________ ☐ Male ☐ Female

School: ______________ Grade: ________ Child's Home #: (____) ________

Child's Home Address (City, State, Zip, Apt/Condo #): ______________

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: ______________ Relation: ________

Do you have legal custody of this child? ☐ Yes ☐ No Is child adopted? ☐ Yes ☐ No In foster home? ☐ Yes ☐ No

Whom may we Thank for referring you? ______________

Other siblings seen by us: ______________

Previous Dentist: ______________ Phone # ________ Last Visit Date: ________

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

PARENT'S INFORMATION

☐ **Mother** ☐ Step Mother ☐ Guardian

Name: ______________ Birthdate: ____/____/____

Address ______________ E-Mail ________

Wk #: (____) ________ Ext: ____ Hm #:(____) ________ Cell #:(____) ________

Employer: ______________ SS #: ________ DL #: ________

☐ **Father** ☐ Step Father ☐ Guardian

Name: ______________ Birthdate: ____/____/____

Address ______________ E-Mail ________

Wk #: (____) ________ Ext: ____ Hm #:(____) ________ Cell #:(____) ________

Employer: ______________ SS #: ________ DL #: ________

Neighbor or Relative not living with you.

Name: ______________ Phone: (____) ________

Address (City, State, Zip): ______________

Primary Dental Insurance

Insurance Co. Name: ______________ Phone #: (____) ________

Policy Owner's Name: ______________ Group # (Plan, Local, or Policy #): ________

Policy Owner's Birthdate: ____/____/____ SS #: ________ Relationship to Patient: ________

Policy Owner's Employer: ______________

Secondary Dental Insurance

Insurance Co. Name: ______________ Phone #: (____) ________

Policy Owner's Name: ______________ Group # (Plan, Local, or Policy #): ________

Policy Owner's Birthdate: ____/____/____ SS #: ________ Relationship to Patient: ________

Policy Owner's Employer: ______________

WHERE KIDS ARE DINO-MITE

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

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: ______________________________

____

Please list all drugs/things that the child is allergic to: ______________________________

____

Has the child ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N ADD / ADHD
Y N Anemia
Y N Autism
Y N Cancer
Y N Artificial Joints/Valves
Y N Asthma
Y N Hospital Stays
____
Y N Surgeries
____

Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions
Y N Diabetes
Y N Down Syndrome
Y N Epilepsy
Y N Exposed to HIV, but Neg:
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Premed Needed

Y N Hemophilia
Y N Hepatitis Type: __________
Y N Hives
Y N HIV+ / AIDS
Y N Juv Arthritis
Y N Kidney / Liver Problems
Y N Measles
Y N Mononucleosis
Y N Rheumatic / Scarlet Fever
Y N Sickle Cell Disease / Traits
Y N Skin Rash
Y N Tuberculosis (TB)

Are the Child's Immunizations current? ☐ Yes ☐ No If No, explain ______________________________

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

Please discuss any serious medical problems that the child has had: ______________________________

____

Does / did the child have any of the following habits?

Y N Lip Sucking
Y N Nail Biting

Y N Nursing Bottle Habits
Y N Thumb / Finger Sucking
Y N Pacifier Habit

Was the child breast fed? ☐ Yes ☐ No How long: ______________________________

Our office 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.

My method of payment will be: ____________ Signature of parent or guardian ______________________ Date __________

I certify that my child is covered by ______________________ Insurance Co. and I assign directly to Dr. ______________________ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment 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 __________

The Parent or Guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been approved.

I have received the Notice of Privacy Practices. Signature ______________________________ Date __________

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WHERE KIDS ARE DINO-MITE