

# Welcome!

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 good oral care that will enable your child to have **a beautiful smile that lasts a lifetime**.

**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.**

# 1

## ABOUT YOUR CHILD

Name: \_\_\_\_\_  
Last First Initial

Nickname: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  
Month Day Year

SS #: \_\_\_\_\_ Age: \_\_\_\_\_

Special interests, sports or hobbies: \_\_\_\_\_

Home address: \_\_\_\_\_  
Apt/Condo # City State Zip Code

Home phone: (\_\_\_\_) \_\_\_\_\_

Referred by: \_\_\_\_\_

# 2

## ABOUT YOU

Your name: \_\_\_\_\_

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

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

Relationship to child: \_\_\_\_\_

Your home phone and address, if different from child's:  
 Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_  
Apt/Condo # City State Zip Code

Occupation: \_\_\_\_\_

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

Work phone: (\_\_\_\_) \_\_\_\_\_

Cell phone: (\_\_\_\_) \_\_\_\_\_

# INSURANCE

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## DENTAL INSURANCE COMPANY #1

Dental Ins. Co.: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group / Policy #: \_\_\_\_\_

**This Dental Insurance is provided through:**

Policy owner's name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Policy owner's SS #: \_\_\_\_\_

Policy owner's birthdate: \_\_\_\_\_

Policy owner's employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
City State Zip

## DENTAL INSURANCE COMPANY #2

Dental Ins. Co.: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group / Policy #: \_\_\_\_\_

**This Dental Insurance is provided through:**

Policy owner's name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Policy owner's ID #: \_\_\_\_\_

Policy owner's birthdate: \_\_\_\_\_

Policy owner's employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
City State Zip

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# DENTAL/MEDICAL HISTORY

Has your child been to the dentist before?  Yes  No

If yes, the approximate date of last visit: \_\_\_\_\_

Are there any dental problems that you are aware of at present?  Yes  No If yes, please explain: \_\_\_\_\_

Does your child brush his / her teeth daily?  Yes  No

Please rate your child's oral health:  Good  Fair  Poor

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

Child's physician: \_\_\_\_\_

His / Her phone #: \_\_\_\_\_

The approximate date of last visit: \_\_\_\_\_

Please rate your child's medical health:  Good  Fair  Poor

**Is your child allergic to any drugs or other things?**  Yes  No

If yes, please list: \_\_\_\_\_

Is your child taking any prescription drugs?  Yes  No

If yes, please list: \_\_\_\_\_

**Does your child require antibiotics before dental treatment?**  Yes  No

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**Has your child ever had any of the following medical conditions or problems?**

- Y  N Any Hospital Stays
- Y  N Any Operations
- Y  N Bleeding Problems of Any Kind
- Y  N Cancer
- Y  N Convulsions / Epilepsy
- Y  N Diabetes
- Y  N Hearing Impairment
- Y  N Heart Murmur
- Y  N Heart Problems of Any Kind
- Y  N Hemophilia
- Y  N HIV+ / AIDS
- Y  N Hyperactive
- Y  N Rheumatic / Scarlet Fever

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**In the event of any emergency, whom should we contact?**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone #2: \_\_\_\_\_

Are there any other medical conditions or problems relating to your child?  Yes  No

If yes, please list: \_\_\_\_\_



I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of 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.



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

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**T**hank you for filling out this form completely. It will enable us to give your child the best dental care possible. If you or your child have any questions, please feel free to ask us at any time.



# Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

## 1 ABOUT YOU

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

E-mail Address: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Last First Mi Mr Mrs Ms Dr

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SS#: \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
Apt/Condo #

\_\_\_\_\_ City State Zip

Single  Married  Partnered  Divorced/Separated  Widowed

Hm #: (\_\_\_\_) \_\_\_\_\_ Cell / Other #: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ DL #: \_\_\_\_\_

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

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

\_\_\_\_\_ City State Zip

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_

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

Other family members seen by us: \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_  
(Please Circle)

**Person Responsible for Account:** \_\_\_\_\_

## 2 SPOUSE INFORMATION

His / Her Name: \_\_\_\_\_

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

Contact #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ DL #: \_\_\_\_\_

### Relative or Friend not living with you (for emergency).

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Contact #: (\_\_\_\_) \_\_\_\_\_

## 3 INSURANCE

### Primary Insurance

Dental Coverage?  Yes  No

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

Insurance Co. Address: \_\_\_\_\_

\_\_\_\_\_ City State Zip

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

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

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

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

\_\_\_\_\_ City State Zip

### Secondary Insurance

Dental Coverage?  Yes  No

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

Insurance Co. Address: \_\_\_\_\_

\_\_\_\_\_ City State Zip

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

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

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

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

\_\_\_\_\_ City State Zip

**Payment is due in full at the time of treatment**  
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature \_\_\_\_\_

Date \_\_\_\_\_

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# 4 MEDICAL HISTORY

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

Do you smoke or use tobacco in any other form?  Yes  No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath?  Yes  No

Have you had any metal rods, pins or implants?  Yes  No

Are you taking any prescription / over-the-counter drugs?  Yes  No

Please list each one: \_\_\_\_\_

Have you ever taken Fosamax, or any other bisphosphonate?  Yes  No

**For Women:** Are you using a prescribed method of birth control?  Yes  No

Are you pregnant?  Yes  No Week #: \_\_\_\_\_

Are you nursing?  Yes  No

### Have you ever had any of the following diseases or medical problems?

- |  |  |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding / Hemophilia     | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters      |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS                               | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse               | <input type="checkbox"/> Y <input type="checkbox"/> N HIV                          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                             | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis                          | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems              |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease                |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                             | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion                  | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus                        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy              | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis                            | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect            | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                           | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing               | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema                          | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                           | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells                    | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches                 | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma                           | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever                          | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Surgery             | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur                       | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                          | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease             |

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

### Are you allergic to any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin            | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin   | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine            | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry/Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex          | <input type="checkbox"/> Y <input type="checkbox"/> N Other        |

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_



# 5 DENTAL HISTORY

Why have you come to the dentist today? \_\_\_\_\_

Are you currently in pain?  Yes  No

Do you require antibiotics before dental treatment?  Yes  No

Your current dental health is:  Good  Fair  Poor

Have you ever had a serious/difficult problem associated with any previous dental work?  Yes  No

Do you floss daily?  Yes  No Brush daily?  Yes  No

Type of bristles on your toothbrush?  Hard  Medium  Soft

Have you ever had gum treatment?  Yes  No

Do your gums ever bleed?  Yes  No Ever Itch?  Yes  No

Have you ever had periodontal disease?  Yes  No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?  Yes  No

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_

Do you have any loose teeth?  Yes  No

Do you still have wisdom teeth?  Yes  No

Would you like fresher breath?  Yes  No Whiter teeth?  Yes  No

Are you happy with the way your smile looks?  Yes  No

If not, what would you change? \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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.

## MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit?  Y  N  
If Yes, please explain. \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health status since your last visit?  Y  N  
If Yes, please explain. \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_