Child's Information

Your Child: ______________________________ Date: 09/16/2021

Last, First MI (Preferred Name)

Gender: ____________ Age: ______________

Child's Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ____________ School: ______________ Grade: ____________

Child's Home Address: ______________________________

Street Apartment #

____

City State Zip Code

Health Information

Date of Last Dental Visit: ____________ Reason for that visit: ____________________

Has your child ever had any of the following? Please check those that apply:

MEDICAL HISTORY

- ☐ AIDS/HIV
- ☐ Allergies __________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Eye Disorders
- ☐ Handicaps/ Disabilities
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur / MVP
- ☐ Hepatitis / Jaundice
- ☐ Immune Disorders
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disorders

DRUG ALLERGIES

- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other Drug Allergies

DENTAL HISTORY

- ☐ Bad Breath
- ☐ Bite/ Chew Nails
- ☐ Biteguard Therapy
- ☐ Bleeding Gums
- ☐ Bleaching Treatment
- ☐ Blisters/ Sores on Lips
- ☐ Clench/ Grind Teeth
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Severe Gag Reflex
- ☐ Speech Therapy
- ☐ Suck Thumb/ Finger
- ☐ Wisdom Teeth removed

- Has your child ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Is your child under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Name of Physician: ______________________________ Phone: ____________

  ☐ Prescribed Medications: ______________________________
- Does your child have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ____________

Name of person or office referring you to our practice: ______________________________

Parent or Responsible Party Information

The following is: ☐ Mother ☐ Stepmother ☐ Father ☐ Stepfather ☐ Guardian

Name: ______________________________

☐ Male ☐ Female

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ____________ (Work): ____________ Ext: _____ Best time to call: __________

Address: ______________________ Cell Phone (optional) ______________

Street Apartment #

City State Zip Code E-MAIL ADDRESS

Employment Information

The following is for the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ______________________

Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________

Street City State Zip Code

Insured's Employer Name: ______________________

Address: ______________________

Street City State Zip Code

Patient's relationship to insured: ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ______________________

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Secondary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________

Street City State Zip Code

Insured's Employer Name: ______________________

Address: ______________________

Street City State Zip Code

Patient's relationship to insured: ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ______________________

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Consent for Services

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information could be dangerous to my child's health. It is my responsibility to inform your office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/ or other health practitioners.

____ Date: ____________ Relationship to Patient: ___________________
Signature of parent or guardian