

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!



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 _____



General Information

Who is accompanying the child today?
Name: _____ Relation: _____

Yes No
Do you have legal custody of this child?

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 _____



Parent's Information

Person Responsible for Account: _____ Parent's Marital Status: Single Married Partnered Widowed Divorce 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 #): _____

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 #): _____



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

U.S.A.

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Dental History

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

Has the child ever taken Fosamax, or any other bisphosphonate? Yes No

Has your child ever taken Phen-Fen? Yes No

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 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

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

OFFICE USE ONLY OFFICE USE ONLY

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. _____

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

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 _____