

# Welcome

## Tell Us About Your Child:

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Nickname: \_\_\_\_\_  Male  Female

Hobbies: \_\_\_\_\_ School: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

## Father's Information:

- Married  Single  
 Guardian  Step-Father  
 Foster Parent

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

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

Driver's License: \_\_\_\_\_ Exp: \_\_\_\_\_

## Mother's Information:

- Married  Single  
 Guardian  Step-Mother  
 Foster Parent

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

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

Driver's License: \_\_\_\_\_ Exp: \_\_\_\_\_

## Who is accompanying the child today?

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

Relation: \_\_\_\_\_

Contact E-mail: \_\_\_\_\_

Do you have legal custody of this child?

- Yes  No

In case of an emergency, please call:

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

Phone: \_\_\_\_\_

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

Name and phone # of nearest relative not living with you: \_\_\_\_\_

## Person responsible for account:

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

Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work #: \_\_\_\_\_

Alt. Phone #: \_\_\_\_\_

## Who may we thank for referring you?

- Patient  Doctor  Other

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

Address: \_\_\_\_\_

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

## Insurance Information:

### ASK US IF WE ARE IN NETWORK

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

Insured's Date of Birth: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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

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

Employer's Phone: \_\_\_\_\_

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

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

Insurance Co. Phone: \_\_\_\_\_

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

For our patients with dental insurance, we will be happy to file insurance claims for you as long as your insurance can be verified. We ask you to pay all non-covered fees as treatment progresses. If we do not receive payment within five (5) weeks after treatment, you will be expected to pay for all dental services. In the event of a duplicate payment, you will be reimbursed.

Signature of Parent/ Guardian \_\_\_\_\_

Date \_\_\_\_\_

Previous/ Present Dentist:

\_\_\_\_\_

**Child's Pediatrician:**

\_\_\_\_\_

Phone #:

Date of last visit:

\_\_\_\_\_

Is your child currently under the care of a physician?

- Yes
- No

Please describe your child's current physical health:

- Good
- Fair
- Poor

**Please list all drugs that the child is allergic to:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list all drugs that the child is currently taking:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child have any of the following habits?

Yes No

- Thumb/ Finger Sucking
- Lip Sucking/ Biting
- Nail Biting
- Nursing/ Bottle Habits
- Mouth Breathing
- Nighttime Grinding of Teeth

Does your child have a **Heart Condition?**

(Such as a heart murmur)

- Yes
- No

**Explain if yes:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If yes, child's cardiologist's Name and Phone number:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does the child have/ or ever had any of the following medical problems?

Yes No

- Cancer
- Diabetes
- Rheumatic Fever
- HIV +/- AIDS
- Hemophilia
- Asthma
- Hepatitis
- Tuberculosis (TB)
- Chronic upper  
Respiratory problems
- Convulsions/ Epilepsy
- Abnormal Bleeding
- Hearing Impairment
- Any Operations
- Any Hospital Stays
- Kidney/ Liver problems
- Handicaps/ Disabilities
- Allergies
- Pregnant
- Smoker
- ADD & ADHD
- Developmentally Delayed
- Autism/PDD-NOS

**Please discuss any serious medical problems that your child has/had:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is the reason for today's visit?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 also authorize the doctors and the dental staff to perform any necessary dental services my child may need. The responsible party is the parent who brings the child to the dental office, independent of what a divorce decree may state. Reimbursement must be made between the divorced parties. We will not intervene.

Signature of Parent/Guardian

Date

Signature of Person Accompanying Child

Date