

1 About Your Child:

Name: _____
 Last First Initial
 Nickname: _____ Birthday: ___/___/___
 M D Y
 SS# _____ Age: ___ Male or Female
 Home Address: _____
 Apt/Condo# City State Zip Code
 Home Phone: (____) _____

3 Dental Insurance:

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 birthday: _____

 Policy owner's employer: _____
 Employer's Address: _____

 City State Zip
 Code
Secondary Insurance Coverage: YES/NO
 If yes, give info: _____

2 About You:

Your Name: _____
 Last First Initial
 Birthday: ___/___/___ SS# _____
 M D Year
 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: (____) _____

4 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 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**

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

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	Y	N

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: _____

In event of any emergency, Whom should we contact?

Name: _____
 Relationship: _____
 Phone: _____
 Phone #2: _____

