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Your Teeth....Your Health....Our Commitment!

Our dental team welcomes you and your child to our office. We look forward to helping your child develop a positive dental health program which will benefit them the rest of their lives. Healthy smiles are beautiful smiles.

PATIENT INFORMATION

Date _____

Child's Name _____

Prefers to be called _____

Address _____

City _____ State _____ Zip _____

SS# _____ Date of Birth _____

Home Phone# _____

□ Male □ Female

Father's Name _____

Home Phone _____ Work Phone _____

Mother's Name _____

Home Phone _____ Work Phone _____

Parent's Marital Status: □ Married □ Single □ Separated □ Divorced □ Widowed

Patient lives with: □ Mother □ Father □ Both □ Other _____

DENTAL INSURANCE

Insured's Name _____

Relationship _____

Insured's Date of Birth _____

Insured's SS # _____

Insured's Employer _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Name _____ Relationship _____

MEDICAL HISTORY

Physician _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Taking any medications? □ Yes □ No List: _____

Allergies to medications? □ Yes □ No List: _____

Any history or difficulty with the following:

□ Anemia	□ Chicken Pox	□ Hearing Problems	□ Measles
□ Asthma	□ Convulsions	□ Heart Problems	□ Mitral Valve Prolapse
□ Bladder Problems	□ Diabetes	□ Hepatitis	□ Mononucleosis
□ Cancer	□ Epilepsy	□ HIV-Aids	□ Mumps
□ Cerebral Palsy	□ Fainting	□ Kidney Disease	□ Rheumatic Fever

□ Other (explain) _____

_____

DENTAL HISTORY

Date of last visit to a dentist? _____

□ Check-up □ Emergency □ Other (explain) _____

Current dental problems? _____

Any injuries to mouth, teeth, head? _____

Past dental experiences? □ Favorable □ Unfavorable

Brush teeth daily? □ Yes □ No How Often? _____

Do the gums ever bleed when brushing teeth? □ Yes □ No □ Occasionally

Floss teeth? □ Yes □ No □ Occasionally

Is fluoride taken in any form? □ Yes □ No How often? _____

Do you...

Bite fingernails?	□ Yes	□ No	Clench teeth?	□ Yes	□ No
Suck thumb/fingers?	□ Yes	□ No	Grind teeth?	□ Yes	□ No
Chew hard objects? (pencils, etc.)	□ Yes	□ No	Sleep with bottle?	□ Yes	□ No
Breathe through mouth?	□ Yes	□ No	Chew gum often?	□ Yes	□ No
Have difficulty with speech?	□ Yes	□ No	Sugarless?	□ Yes	□ No

What do you drink most often during the day? _____

With meals? □ Yes □ No Between meals? □ Yes □ No Sip frequently? □ Yes □ No

As a parent how much anxiety do you feel when at the dentist? □ Very Much □ Moderate □ Some

AUTHORIZATION

I authorize the doctor and staff to take needed x-rays and perform diagnostic procedures and examinations necessary to make a through diagnosis of my child's dental needs.

I understand I will be given the opportunity and am encouraged to ask questions concerning my child's dental condition, contemplated or a alternative treatment, procedures and associated risks.

I authorize the doctor and staff to perform mutually agreed upon treatment and procedures and use medications and anesthetics that may be necessary for proper dental care. I understand any medications used including anesthetics embodies some risk. I further understand that unforeseen conditions can arise during the course of treatment which may call for procedures in addition to, or different from those originally contemplated and I will be informed, whenever possible, prior to these additional or changed procedures

I agree to be responsible for payment for dental services provided in this office from my child, due and payable at the time services are rendered unless specific financial arrangements have been made prior to treatment.

Parent's or Guardian's Signature _____ Date _____