

(for office use)

Welcome!

to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Your Child

Name: _____

Nickname: _____ Sex: _____

Birthdate: _____ Age: _____

Address: _____

Home #: _____

School: _____ Grade: _____

Mother's Information

Mother _____ Step Mother _____ Guardian _____

Name: _____

Employer/Work Phone: _____

Occupation: _____ SS# _____

Cell #: _____ Text: Yes or No

Email: _____

Father's Information

Father _____ Step Father _____ Guardian _____

Name: _____

Employer/Work Phone: _____

Occupation: _____ SS# _____

Cell # _____ Text: Yes or No

Email: _____

DATE: _____

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Elkhart, IN 46514

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Parent's Marital Status

___ single ___ married ___ separated ___ divorced
___ widowed

Primary Dental Insurance

Mom/Step-mom Dad/Step dad Guardian

Name: _____

Employer: _____

Insurance Company: _____

Member ID# _____
(ID# on card)

Insured's Social Security # _____ Insured's Birthdate: _____

Medicaid # _____

Secondary Dental Insurance

Mom/Stepmom Dad/Stepdad Guardian

Name: _____

Employer: _____

Insurance Company: _____

Member ID# _____
(ID# on card)

Insured's Social Security # _____ Insured's Birthdate: _____

Medicaid # _____

Who referred you to our office?

Dental History

Is this the first visit to the dentist? _____

Previous dental visit information:

Dentist's Name: _____

X-rays taken: _____

Last Cleaning: _____

Injuries to teeth, mouth, face: _____

Explain: _____

Dental Habits/Health

Is your water fluoridated ___Yes ___No

Does your child:

Take fluoride supplements ___Yes ___No

Brush Daily ___Yes ___No

Floss Daily ___Yes ___No

Suck thumb/finger ___Yes ___No

Use a Pacifier ___Yes ___No

Bite/chew Nails ___Yes ___No

Chew hard objects (toys etc) ___Yes ___No

Grind Teeth ___Yes ___No

Clench Jaw ___Yes ___No

Difficulty with previous visits ___Yes ___No

If yes, explain: _____

Health History

Physician: _____

Phone # _____

List any medication your child is currently taking and what the medication is for:

Has your child had any of the following conditions?

Allergies (including Medication) ___Yes ___No

If yes, explain: _____

Heart Condition/Heart Murmur ___Yes ___No

If Yes, explain: _____

Antibiotic for dental visits required ___Yes ___No

Cardiologist Name: _____

Phone Number: _____

CIRCLE YES OR NO TO THE FOLLOWING:

Acid Reflux YES/NO Birth Defects YES/NO

Hospital stays YES/NO Operations YES/NO

Asthma YES/NO Cancer YES/NO

Hepatitis YES/NO HIV/AIDS YES/NO

Diabetes YES/NO Disability YES/NO

Pregnancy YES/NO Hemophilia YES/NO

Abnormal Bleeding YES/NO Transfusions YES/NO

Persistent cough YES/NO Anemia YES/NO

Convulsions/Epilepsy YES/NO Tuberculosis YES/NO

Autism YES/NO Sensory Issues YES/NO

Seizures YES/NO

Handicap/Disability/Special Needs YES/NO

If yes, explain: _____

I understand that the information 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.

I understand that the office will file my dental insurance as a courtesy and that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Signature of parent/guardian of patient

Date: _____