____
(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:** ________

School: _________________________ **Grade:** ____

Address: ________________________________

____

Home #: ________________________________

Mother's Information

Mother ____ Step Mother ____ Guardian ____

Name: ________________________________

Employer/Work Phone:__________________________

Occupation: ______________________________

Cell #: __________________________ **Text: Yes or No**

Email: ________________________________

Father's Information

Father ____ Step Father ____ Guardian ____

Name: ________________________________

Employer/Work Phone:__________________________

Occupation: ______________________________

Cell # __________________________ **Text: Yes or No**

Email: ________________________________

DATE: ________________________

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Elkhart, IN 46514
574-264-9499
fax: 574-264-7883
robbinsdental@frontier.com

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 you 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: ________________________________