

ABOUT YOUR CHILD

Child's Name: _____
LAST FIRST MI

Child's nickname: _____ Boy Girl

Child's Birthdate: ____/____/____ Age: ____

School: _____ Grade: ____

Child's Home Phone #: (____) _____ -- _____

Child's SS# _____ -- _____ -- _____

Child's Address: _____

CITY STATE ZIP

Referred by: _____

(If doctor, please give address and phone #.)

INSURANCE INFORMATION

Primary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: () _____ -- _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Does either policy cover Orthodontics? Yes No

Secondary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: () _____ -- _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

CHILD'S FAMILY INFORMATION

Who is accompanying this child today?

FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? Yes No

How many Brothers/Sisters? ____ Age(s)? ____

Mother's Name: _____

STEPMOTHER GUARDIAN

(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(____) _____ -- _____ (____) _____ -- _____ Ext. ____

HOME PHONE # WORK PHONE #

MOTHER'S SS# DATE OF BIRTH MOTHER'S DRIVERS Lic. #

Employer: _____ How Long? ____

EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____

STEPFATHER GUARDIAN

(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(____) _____ -- _____ (____) _____ -- _____ Ext. ____

HOME PHONE # WORK PHONE #

FATHER'S SS# DATE OF BIRTH FATHER'S DRIVERS Lic. #

Employer: _____ How Long? ____

EMPLOYER'S ADDRESS CITY STATE ZIP

ACCOUNT INFORMATION

Person ultimately responsible for account

Name: _____

RELATION TO CHILD

Billing Address: _____

CITY STATE ZIP

SOCIAL SECURITY# DATE OF BIRTH DRIVERS LICENSE #

(____) _____ -- _____ (____) _____ -- _____ Ext. ____

CELL PHONE # WORK PHONE #

Payment method: Cash Check

Credit Card - Enter card # above (if accepted) Exp Date

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initials

CHILD'S DENTAL INFORMATION

Reason for today's visit: Exam Emergency Consultation

Is Child in pain? No Yes How long? _____

Please indicate any of the following problems:

- | | | |
|--|---|--|
| <input type="checkbox"/> Discomfort, clicking or popping in jaw. | <input type="checkbox"/> Lost/Broken Filling(s) | <input type="checkbox"/> Stained teeth |
| <input type="checkbox"/> Red, Swollen or bleeding gums. | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Locking jaw |
| <input type="checkbox"/> Sensitive tooth, teeth or gums. | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Bad Breath |
| <input type="checkbox"/> Blisters/Sores in or around the mouth. | <input type="checkbox"/> Broken/Chipped tooth | <input type="checkbox"/> Loose tooth |
| <input type="checkbox"/> Other(s): _____ | | |

Does child require pre-medication? Yes No Don't know

Previous Dentist: _____ (____) _____--_____

Last dental exam? ____/____/____ Last dental x-rays? ____/____/____

of times a day child brushes? ____ # of times a week child flosses? ____

Is the child's water fluoridated? Yes No

How would you rate the child's smile? Best 1 2 3 4 5 6 7 8 9 10 Worst

CHILD'S MEDICAL HISTORY

Is Child taking any of the following medications? Pain killers (including aspirin) Ritalin

Stimulants Blood Thinners Tranquilizers Insulin Muscle Relaxers

Other(s): _____

Child's Physician: _____ Physician's Phone #: (____) _____--_____

Physician's Address: _____ Last Medical Exam: ____/____/____
CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Asthma/Difficulty Breathing | <input type="checkbox"/> Liver/Kidney/Organ Problems |
| <input type="checkbox"/> Congenital Heart defect | <input type="checkbox"/> Blood Transfusion(s) | <input type="checkbox"/> Artificial Bones/Joints/Implants |
| <input type="checkbox"/> Surgeries/Operations | <input type="checkbox"/> Leukemia/Anemia | <input type="checkbox"/> HIV+/AIDS/ARC |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Diabetes/Hypoglycemia | <input type="checkbox"/> Tuberculosis TB |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia/Abnormal Bleeding | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Jaw Problems TMJ/TMD | <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Hyper Active/ADD |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Cerebral Palsy |

Please list any other medical condition(s) child has or ever had: _____

Is child allergic to: Latex Penicillin/Amoxicillin Tetracycline Aspirin Food Allergies

Dental Anesthetics (Novocaine) Other(s): _____

Please rate the child's general health from 1-10: _____ Does child wear contact lenses? Yes No

Has this child ever taken the drug Ritalin? No Yes/How Long? _____ Child's Blood Type: _____

Does this child do any of the following? Thumb/Finger Sucking Tongue Thrusting/Sucking

Heavy Snoring Mouth Breathing Lip Sucking/Biting

Signature _____ Date ____/____/____

Parent or Guardian Other: