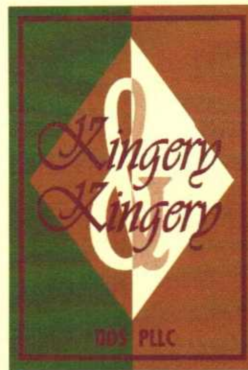
Welcome!

Our goal is to make every patient's visit pleasant and educational. We believe in preventive maintenance; therefore we teach good home oral care so you and your child may enjoy a beautiful smile for a lifetime. The more we know about you and your child, the better we can assist both of you. Thank you.



Warm Hearts, Beautiful Smiles

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About your child

Child's name ________________ (Last) ________________ (First) ________________ (Middle) Nickname ________________

Child's birthdate ________________ School ________________ Grade ________________

Child's home# ________________ SS# ________________

Child's home address ________________ (Street/Apt/Condo) ________________ (City) ________ (State) ________ (Zip)

Who is accompanying your child?

Name ________________ (Last) ________________ (First) ________________ (Middle) Relationship to child ________________

Do you have legal custody of the child? ______ Whom may we thank for referring you? ________________

Other family members seen by us? ________________

In case of emergency, contact ________________ (Name (other than immediate family member)) ________________ (Address) ________________ (Phone)

Previous dentist ________________ Last visit date ________________

Parent's marital status (circle): Single Married Divorced Separated Widowed

*Please note that the parent or guardian accompanying the child today will be listed as the responsible party regardless of insurance or marital status unless signed written consent or legal documentation is presented.

Parent information

Mother's name ________________ Home# ________________ Work# ________________

Employer ________________ Occupation ________________

SS# ________________ Driver's license# ________________

Father's name ________________ Home# ________________ Work# ________________

Employer ________________ Occupation ________________

SS# ________________ Driver's license# ________________

Primary insurance

Insurance co. name ________________ Insured's name ________________

Insurance co. address ________________ (Street) ________________ (City) ________ (State) ________ (Zip)

Phone# ________________ Group# ________________ Relationship to patient ________________

Insured's employer ________________ Insured's birthdate ________________

More about you

Why are you visiting the dentist today? ______

Y N Have you ever had a serious/difficult problem associated with previous dental work? Please explain ______

Y N Has there been any injury/trauma to the teeth? Please explain ______

Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? ______

Y N Do you floss daily? How often? ______

Your current physical health is (circle): Good Fair Poor

Physician ______ Phone# ______ Last visit date ______

Y N Do you smoke/use tobacco in any form? Y N Do you use alcohol, cocaine/other drugs?

Y N Have you ever taken Fen-Phen/Redux?

Please list all drugs that you are currently taking ______

Women:

Y N Are you pregnant/do you think you may be pregnant? Y N Do you take birth control pills? (please name) ______

Are you/have you ever had an allergic reaction to:

Y N Aspirin	Y N Iodine	Y N Penicillin/other antibiotics	Y N Other ______
Y N Barbiturates/Sedatives	Y N Local anesthetics	Y N Sulfa drugs	______

Do you have/have you ever had the following:

Y N Fainting spells/seizure	Y N Heart attack	Y N Low blood pressure	Y N Stroke
Y N Heart trouble	Y N Heart surgery	Y N Lung/breathing problems	Y N Other ______

If you answered yes to heart attack/heart surgery, please explain ______

Have you experienced any of the following medical conditions?

Y N Abnormal bleeding	Y N Convulsions/epilepsy	Y N HIV+/AIDS	Y N Replacement joints/ implants
Y N Anemia	Y N Diabetes	Y N Hospital stays	
Y N Asthma	Y N Frequent nose bleeds	Y N Kidney/liver problems	Y N Tuberculosis (TB)
Y N Blood transfusions	Y N Handicap/disabilities	Y N Latex allergies	Y N Other ______
Y N Blood clots	Y N Hearing impairment	Y N Mitral valve prolapse	______
Y N Brain injury	Y N Heart murmur	Y N Operations	______
Y N Cancer	Y N Hemophilia	Y N Pregnancy	______
Y N Congenital heart defect	Y N Hepatitis	Y N Rheumatic fever	______

If yes to any of the above, please explain ______

______

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 medical status. I authorize the dental staff to perform the necessary dental services I may need. I also authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand 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 my behalf or my dependents.

______ Signature of parent or guardian

______ Date