Welcome to Our Practice

Date:_____

1. ***Tell us about your child***:

Name: E-mail:_____

Nickname: Male / Female Age: DOB:

Address: _____

Siblings: _____ Who may we thank for referring you?

_____ _____

Responsible Party:
Name: Relation: Phone:

2. ***Contact Information***:

Mother: Marital status:

Phone(h): Phone(c): Phone(w):

Father: Marital status:

Phone(h): Phone(c): Phone(w):

3. ***Current Dentist:***

Name: Phone:

Last visit: Address:_____

4. ***Primary Dental Ins.:***_____ ***Secondary:***_____

Name: DOB: Name: DOB:

Ins. Address:_____ Ins. Address:_____

_____ _____

SS/Policy#: SS/Policy#:

Employer: Relation: Employer: Relation:

5. About the patient:

Has the child ever had a serious/difficult problem associated with dental work? Y / N

Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD)? Y / N

How many times a day do you brush? Floss?

Please describe the child's health: Good Fair Poor

DOCTOR USE ONLY

RMH _____
OCS _____

Does the child have a primary care physician? Y / N Dr. _____Phone:_____

Please list all medications the child is currently taking:

_____

_____

Does the child have any of these habits?

Thumb/finger sucking	Y / N
Lip biting/sucking	Y / N
Nail biting	Y / N
Nursing bottle habits	Y / N

Please list any drug allergies:

_____

_____

Handicaps/disabilities:

_____

Operations:

_____

6. Has the child ever had any of these medical problems? **(please circle)**

Heart murmur	Y / N	Congenital Heart Def.	Y / N
Cancer	Y / N	Abnormal Bleeding	Y / N
Diabetes	Y / N	Prosthesis	Y / N
Rheum Fev.	Y / N	Tuberculosis	Y / N
HIV+/AIDS	Y / N	Asthma	Y / N
Hepatitis	Y / N	Hemophilia	Y / N
Hearing impairment	Y / N		
Hospital stays	Y / N	_____	

"Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA."

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of parent/guardian **Date**

*** The parent/guardian who accompanies this child is responsible for payment at the time of service unless prior arrangements have been approved. ***