

*Agas 2 yrs - 12 yrs*

Patient ID# \_\_\_\_\_

Today's Date \_\_\_\_\_

# 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

Child's Name \_\_\_\_\_  
Nickname \_\_\_\_\_ Sex \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Child's Home Address \_\_\_\_\_  
City \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Phone \_\_\_\_\_

## Responsible Party

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
DL # \_\_\_\_\_  
Email \_\_\_\_\_

## Mother

Stepmother  Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
DL # \_\_\_\_\_

## Primary Dental Insurance

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_ Date Emp. \_\_\_\_\_  
Occupation \_\_\_\_\_

Ins. Company \_\_\_\_\_ Group # \_\_\_\_\_ Emp. # \_\_\_\_\_  
Ins. Company Address \_\_\_\_\_  
Deductible \_\_\_\_\_ Amount already used \_\_\_\_\_ Max. annual benefit \_\_\_\_\_  
Orthodontic coverage  Yes  No

## Additional Insurance

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Employer \_\_\_\_\_

Date Emp. \_\_\_\_\_ Occupation \_\_\_\_\_

Ins. Company \_\_\_\_\_ Group # \_\_\_\_\_ Emp. # \_\_\_\_\_

Ins. Company Address \_\_\_\_\_

Deductible \_\_\_\_\_ Amount already used \_\_\_\_\_

Max. annual benefit \_\_\_\_\_

Orthodontic coverage

Yes  No

## Parent's Marital Status

Single  Divorced

Married  Widowed

Separated

## Who is responsible for making appointments?

Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Cell Phone \_\_\_\_\_

Best time to call (Time) \_\_\_\_\_ (Days) \_\_\_\_\_

Over Please

# Health History

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives.

Please answer each of the following questions completely.

## Health History

Has your child had difficulty with previous visits? \_\_\_\_\_

Does your child have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? \_\_\_\_\_

Has your child ever taken Fen-Phen/Redux? \_\_\_\_\_

Has your child ever had any of the following:

- |   |  |
|---|--|
| Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO     | Rheumatic Fever <input type="checkbox"/> YES <input type="checkbox"/> NO         |
| Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO     | Congenital Heart Defect <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hepatitis <input type="checkbox"/> YES <input type="checkbox"/> NO  | Handicaps/Disabilities <input type="checkbox"/> YES <input type="checkbox"/> NO  |
| HIV/AIDS <input type="checkbox"/> YES <input type="checkbox"/> NO   | Convulsions/Epilepsy <input type="checkbox"/> YES <input type="checkbox"/> NO    |
| Hemophilia <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO            |
| Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO   | Abnormal Bleeding <input type="checkbox"/> YES <input type="checkbox"/> NO       |
| Allergies <input type="checkbox"/> YES <input type="checkbox"/> NO  | Heart Murmur <input type="checkbox"/> YES <input type="checkbox"/> NO            |

Please explain any medical problems that your child has

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Child's Habits

How often does your child brush? \_\_\_\_\_

How often does your child floss? \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

Previous Dentist \_\_\_\_\_

Child's Physician \_\_\_\_\_

Phone Number \_\_\_\_\_

Child's Birthdate \_\_\_\_\_

Is your child's water fluoridated? .....  YES  NO

Does your child take fluoride supplements?  YES  NO

Does your child:

Suck thumb/finger .....  YES  NO

Suck/Bite lips .....  YES  NO

Bite/Chew nails .....  YES  NO

Chew hard objects

(Pencils, etc.) .....  YES  NO

Grind Teeth  YES  NO

Clench jaws .....

YES  NO

## Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors 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.

X \_\_\_\_\_  
Signature of patient or parent/guardian if minor

Date \_\_\_\_\_

## Dentist's Review

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

Signed Dr. \_\_\_\_\_

## Health History Update

Comments \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_ Comments \_\_\_\_\_

Signature \_\_\_\_\_