

Welcome!

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell us about your child

Today's date: _____

Child's Name: _____

Nickname: _____ Male _____ Female _____

Child's Birthdate: ____/____/____ Child's age: _____

School: _____ Grade: _____

Child's Home #: _____ SS# _____

Child's Home Address: _____

E-Mail address: _____

Who is accompanying the child today?

Name: _____ Relationship: _____

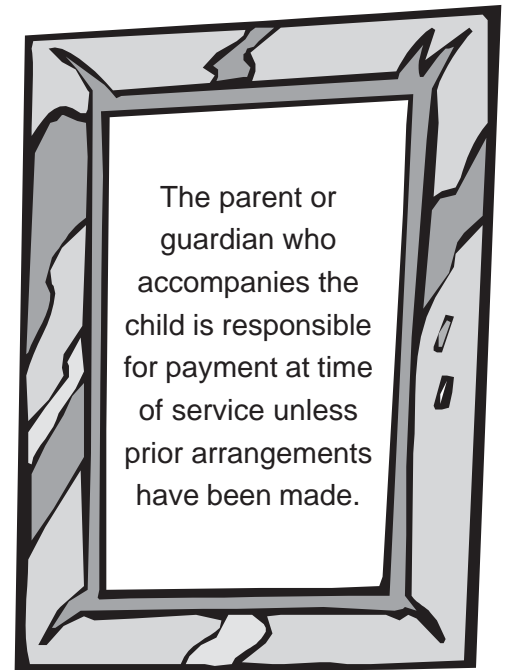
Do you have legal custody of child? Yes _____ No _____

Who may we thank for referring you? _____

Other family members seen by us: _____

Previous/present dentist: _____

Last visit date: _____



Mother's information

Name: Ms Mrs Dr _____

Wk# _____ Ext: _____ Hm# _____

Employer: _____

SS#: _____

Father's information

Name: Mr Dr _____

Wk# _____ Ext: _____ Hm# _____

Employer: _____

SS#: _____



Person responsible for account

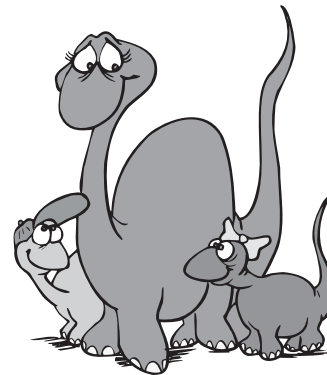
Name: _____ Relation: _____

Billing Address: _____

Wk#: _____ Ext: _____ Hm#: _____

Employer: _____

SS#: _____



Why did you bring the child to the dentist today?

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

Yes _____ No _____

Is the child's water fluoridated? Yes _____ No _____

Is the child taking fluoride supplements? Yes _____ No _____

Has the child ever had any pain/tenderness in their jaw joint (TMJ/TMD) Yes _____ No _____

Does the child brush his/her teeth daily? Yes _____ No _____

Floss his/her teeth daily? Yes _____ No _____

Child's Physician: _____

Phone#: _____ Date of last visit: _____

Is the child currently under the care of a physician? Yes _____ No _____

Please describe the child's current physical health:

Good _____ Fair _____ Poor _____

Has the child ever had any of the following medical problems?

Y	N	Heart murmur	Y	N	Congenital heart defect
Y	N	Cancer	Y	N	Convulsions/Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheumatic fever	Y	N	Hearing Impairment
Y	N	HIV+/AIDS	Y	N	Any operations
Y	N	Hemophilia	Y	N	Any stays in hospital
Y	N	Asthma	Y	N	Kidney/Liver Problems
Y	N	Hepatitis	Y	N	Handicaps/Disabilities
Y	N	Tuberculosis	Y	N	Allergies to any drugs

Please discuss any problems that the child has had:

Has your child received regular six-month dental care? Yes _____ No _____ not applicable _____

Does the child have any of the following habits?

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

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

Signature of parent or guardian _____