

## FOR CHILDREN: WELCOME TO OUR PRACTICE

### 1.) TELL US ABOUT YOUR CHILD

Today's date: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Child's Name: \_\_\_\_\_ AGE: \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ Mi \_\_\_\_\_  
 Nickname: \_\_\_\_\_ Male  Female

School: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Home #: \_\_\_\_\_  
 SS #: \_\_\_\_\_  
 Child's Home Address: \_\_\_\_\_  
 \_\_\_\_\_ Apt# \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### 2.) WHO IS WITH THE CHILD TODAY?

Name: \_\_\_\_\_  
 Relation: \_\_\_\_\_  
 Do you have legal custody of this child?  
 YES  NO   
 Who may we thank for referring you? \_\_\_\_\_  
 Other family members seen by us: \_\_\_\_\_  
 Previous/Present Dentist: \_\_\_\_\_  
 Last Visit: \_\_\_\_\_  
 Parent's Marital Status: \_\_\_\_\_  
 (single, married, divorced)

### 3.) MOTHER'S INFORMATION:

Name: \_\_\_\_\_  
 WK#: \_\_\_\_\_ Ext. \_\_\_\_\_ HM#: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 DL#: \_\_\_\_\_  
 SS#: \_\_\_\_\_

### FATHER'S INFORMATION:

Name: \_\_\_\_\_  
 WK#: \_\_\_\_\_ Ext. \_\_\_\_\_ HM#: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 DL#: \_\_\_\_\_  
 SS#: \_\_\_\_\_

### 4.) RESPONSIBLE PARTY INFO:

Name: \_\_\_\_\_  
 Billing address: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 WK#: \_\_\_\_\_ Ext. \_\_\_\_\_ HM# \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 DL#: \_\_\_\_\_  
 SS#: \_\_\_\_\_  
**Who is responsible for making appts?**  
 Name: \_\_\_\_\_  
 WK#: \_\_\_\_\_ Ext. \_\_\_\_\_ HM# \_\_\_\_\_

### 5) PRIMARY DENTAL INSURANCE:

Ins. Name: \_\_\_\_\_  
 Ins. Address: \_\_\_\_\_  
 Insurance Co. Phone #: \_\_\_\_\_  
 Group/Policy # \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Insured's DOB: \_\_\_\_\_  
 Insured's Employer: \_\_\_\_\_  
 SS#: \_\_\_\_\_  
 Orthodontic Coverage: YES  NO

### SECONDARY DENTAL INSURANCE

Ins. Name: \_\_\_\_\_  
 Ins. Address: \_\_\_\_\_  
 Insurance Co. Phone #: \_\_\_\_\_  
 Group/Policy # \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Insured's DOB: \_\_\_\_\_  
 Insured's Employer: \_\_\_\_\_  
 SS#: \_\_\_\_\_  
 Orthodontic Coverage: YES  NO

**6) Why did you bring the child to the Orthodontist today?**

Has the child ever had a serious/difficult problem associated with dental work? Y N  
 Is the child's water fluoridated? Y N  
 Is the child taking fluoridated supplements? Y N

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

Does the child brush teeth daily? Y N  
 Floss their teeth daily? Y N

Child's Physician: \_\_\_\_\_  
 Phone#: \_\_\_\_\_ Last visit: \_\_\_\_\_

Is the child currently under the care of a physician? Y N

Please describe the child's health:  
 GOOD FAIR POOR

Please list all drugs the child is currently taking: \_\_\_\_\_

Please list all drugs the child is allergic to: \_\_\_\_\_

**7) Has the child ever had any of the following medical problems?**

Y N Heart Murm.	Y N Congenital Heart Def.
Y N Cancer	Y N Convulsions/Epilepsy
Y N Diabetes	Y N Abnormal Bleeding
Y N Rheum. Fev.	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
Y N Prosthesis	Y N History of Scarlet Fever

Please discuss any serious medical problems that the child has had: \_\_\_\_\_

**8) Does the child have any of the following habits?**

Y N Thumb sucking / Finger sucking  
 Y N Lip sucking / biting  
 Y N Nail Biting  
 Y N Nursing Bottle Habits

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

**9) 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 this 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 the child is responsible for payment at time of service unless prior arrangements have been approved.

**OFFICE USE ONLY — OFFICE USE ONLY — OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the parent/guardian & patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's comments: \_\_\_\_\_

**Medical History Update:**

1. Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Comments: \_\_\_\_\_

2. Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Comments: \_\_\_\_\_