

Today's Date _____

Child's Name _____ Sex: M F Nickname _____

Birthdate _____ Age _____ Home Phone _____

Address _____

Siblings Names & Ages _____

Responsible Party

Mother Birthdate ____/____/____ Social Security No. ____ - ____ - ____

Last Name _____ First Name _____ M.I. _____

Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Employed By _____ Work Phone _____

Employer Address _____

Father Birthdate ____/____/____ Social Security No. ____ - ____ - ____

Last Name _____ First Name _____ M.I. _____

Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Employed By _____ Work Phone _____

Employer Address _____

Parent's Marital Status: (Circle one) Married Divorced Separated Single

Legal Guardian: (Circle one) Mom Dad Other (Please Name) _____

Person Financially Responsible For Child _____ Phone _____

Address _____

Emergency Contact: Name _____ Phone _____

Dental Insurance

Primary Insurance Co. _____ Group No. _____

Address _____

Policy Holder _____ Relation To Patient _____

Secondary Insurance Co. _____ Group No. _____

Address _____

Policy Holder _____ Relation To Patient _____

Whom May We Thank For Your Referral _____

I Accept Responsibility For This Account _____

Signature of Parent or Guardian

Patient's Physician _____ Phone # _____

Physician's Address _____

1. Is your child under the care of a physician for any illness or health problem? Yes No

2. Does your child have or ever had any of the following health conditions?

- | | | | | | |
|--|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| Abnormal Bleeding Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Aids or Aids Related Complex | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing Problems | <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 |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma or Other Respiratory Problems ... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis, Jaundice or Liver Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Limb or Implant | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hyperactivity | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bladder Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Learning Disability | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mental Retardation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Premature Delivery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cerebral Palsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pregnancy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Convulsions or Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever or Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ear, Nose or Throat Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emotional Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hyper or Hypo Thyroidism | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please explain "yes" answers _____

3. Does your child have any disease, syndrome or handicap not listed above? Yes No

If yes, describe _____

4. Is your child taking any over the counter drugs or prescription medications? Yes No

If yes, name of medication(s) _____

5. Has your child had any allergies or any adverse side affects to any drugs or medications, including local anesthetic, penicillin, codeine, fluoride, etc.? Yes No

If yes, name of medication(s) _____

6. Has your child ever been hospitalized? Yes No

7. Has your child ever had any surgeries? Yes No

8. Has your child or any relative had a problem with general anesthesia? Yes No

Doctor Notes _____

- 1. Is this your child's first visit to the dentist? Yes No
- 2. Has your child complained about dental problems? Yes No
- 3. When was your child's last trip to the dentist? Yes No

Name of previous dentist _____

- 4. Has your child had an unhappy dental experience? Yes No
- 5. Who brushes your child's teeth? _____ How Often? _____

6. Do you drink well water, city water or bottled water? _____

- 7. Is your child going to sleep with a bottle? Yes No

8. What does the bottle contain: Water Milk Formula Juice Other

- 9. Is your child presently breast feeding? Yes No

- 10. Any oral habits (thumb sucking, pacifiers, nail biting, etc.)? Yes No

- 11. Any history of injuries to mouth, teeth, or head? Yes No

If yes, describe injury _____

The statements on both sides of this form are, to the best of my knowledge true and correct. I agree to report any health changes to the Doctor prior to any treatment. I hereby authorize the Doctor and staff to provide examinations, x-rays and procedures to diagnose oral and dental disease and to provide necessary dental services.

Patients Name

Signature of Parent or Legal Guardian

Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign This Acknowledgment

I, _____, acknowledge that I have been given the opportunity to read a copy of this office's Notice of Privacy Practices, and I am aware that a copy will be made available at my request.

(Please Print Name)

(Date)

(Signature)

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please Specify)