We are pleased to welcome your child to our practice.
Please fill out this form as completely as possible.

Child's Name ______________________________ Phone ________________
Child's Address ____
Birth Date _________ Hobbies/Sports ________________________________
Person Responsible for Account ______________________________________
Address __________________________________ Phone ________________
Employer ____________________________ Business Phone ______________
Business Address ___________________________ Cell Phone _____________
Dental Insurance Company __________________________ Group # __________
Insurance Company Address ____
Subscriber's Name ____________________________ ID # ________________
Subscriber's Birth Date _____________ Subscriber's SS # _________________

Dental History

Dental Problems or concerns today ____________________________________
Has the child had any unfavorable dental experiences? Yes or No
Date of Last Dental Visit ____________ Date of Last X-rays _____________

Does the Child Have or Use Any of the Following – Please Check

___ Sensitive Teeth
___ Swelling or Lumps in Mouth
___ Bleeding Gums
___ Clenching or Grinding Teeth
___ Mouth Breathing
___ Traumatic Injury to Head, Jaw or Teeth
___ Bad Breath
___ Oral Habits: Thumb-Sucking, Nail/Cheek Biting

___ Orthodontic Treatment
___ Between Meal Snacks
___ Well Balanced Diet
___ Fluoride Supplements
___ Topical Fluoride Treatment
___ Dental Floss/Frequency __________
___ Toothbrush/Frequency __________

I have reviewed the information on these forms, and it is accurate to the best of my knowledge. Payment is due in full at time of treatment, unless prior arrangements have been made or insurance information has been given. Patient is responsible for balance not paid by insurance and authorizes payment to be made to the dentist for all insurance submissions. I agree to pay a finance charge of 1.5% per month after 60 days on any unpaid balance.

Parent/Guardian Signature ____________________________ *Date* __________

Medical History

Child's Name ___________________________ Phone ______________________
Physician's Name_________________________ Date of Last Exam ______________

Does the Child Have or Has the Child Had Any of the Following – Please Check

___ Immunizations Current
___ Allergy to Anesthetic
___ Material Allergies (latex,metal,chemicals)
___ Heart Problems/Describe ______________
___ Cancer/Radiation Treatment
___ Diabetes
___ Anemia/Blood Disorder/Hemophilia
___ Excessive Bleeding from a Cut
___ Kidney Disease or Problems
___ Tuberculosis
___ Ulcer/Colitis
___ Liver Problems/Hepatitis
___ Asthma
___ Hay Fever or General Allergies
___ Respiratory Disease
___ Sinus Problems
___ Rheumatic/Scarlet Fever
___ Immune System Disorder (AIDS,HIV)
___ Thyroid Disease/Disorder
___ Convulsions/Epilepsy
___ Food Allergies ______________
___ Fainting/Dizziness

List Any Medications the Child is Taking
____
____
____

List Any Drug or Medication Allergies
____
____
____

Parent/Guardian Signature __________________________ *Date* __________

Medical Update

I Have Reviewed My Child's Health History & Confirm that it Accurately States Past & Present Conditions.

Date	Parent/Guardian Signature	Changes to Health History	Initials Dentist/Hygienist
________	________________________	___________________________	______
________	________________________	___________________________	______
________	________________________	___________________________	______
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