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J qwnqp'Dentistry for Children

""We welcome your child into our practice and we will try to make his/ her dental
""""experience very pleasant. Please complete this form thoroughly because this
""""information is of great value in aiding us to better understand your child.

Child's Name _____
Date of Birth _____ Male _____ Female _____
What is your child called (nickname) _____
Attends what school _____ Grade _____
Child's physician or pediatrician _____
Physician's Phone _____ Family Dentist _____
Who may we thank for referring you to our office _____
Address if know _____
Purpose of visit _____
Name and kind of child's pet, toy, hobby, or sport activity _____

IN CASE OF EMERGENCY: NAME OF NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU

Name _____
Relationship to child _____
Address _____
Home# _____ Wk# _____ Cell# _____

BECAUSE YOUR CHILD IS A MINOR, IT IS NECESSARY THAT SIGNED PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY DENTAL TREATMENT BE PERFORMED

THE SIGNATURE OF A PARENT OR GUARDIAN AFFIXED BELOW AUTHORIZES THE COMPLETION OF ALL AGREED UPON DENTAL TREATMENT AND THE USE OF THOSE METHODS APPROPRIATE THERETO. THIS CONSENT SHALL REMAIN IN FULL FORCE AND EFFECT INTIL CANCELLED BY EITHER PARTY.

I WILL ACCEPT RESPONSIBILITY FOR ANY BILL INCURRED FOR THIS CHILD'S DENTAL TREATMENT:

Signed _____ Date _____

Relationship to child _____

Has your child ever had any of the following medical problems:

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Y	N	Convulsions/ Epilepsy	Y	N	Cancer
Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	Hearing Impairment	Y	N	Rheumatic Fever
Y	N	Any Operations	Y	N	HIV / Aids
Y	N	Any stay in the hospital	Y	N	Hemophilia
Y	N	Kidney / Liver Problems	Y	N	Asthma
Y	N	Allergies to any drugs	Y	N	Hepatitis
Y	N	Congenital Heart Defect	Y	N	Tuberculosis (TB)
Y	N	Is Antibiotic Coverage needed?	Y	N	ADD
Y	N	Heart Murmur, If yes check box	Y	N	ADHD
		____ Functional ____ Non-functional	Y	N	Handicaps/Disabilities

If you have answered yes to any of these questions please explain _____

		Yes	No
1.	Is your child taking medicine? If so, what? _____	___	___
2.	Has your child had any unfavorable reaction or allergy to drugs, including antibiotics (penicillin) and local anesthetic solution? If so, please specify. _____	___	___
3.	Has your child had any history of thumb sucking, finger sucking or did he or she use a pacifier past the age of 1-1 ½ years? _____	___	___
4.	Is this currently an active habit? _____	___	___
5.	Is your child still feeding on the bottle or breast? If no, at what age did this stop? _____	___	___
6.	Has your child had his or her tonsils and/or adenoids removed? _____	___	___
7.	Does your child have or has he or she had in the past, frequent ear and throat infections or tubes in ears? _____	___	___
8.	Has your child had any history of hearing loss, or speech problems? _____	___	___
9.	In your family is there any history of any malocclusions, bad bites, missing or extra teeth? _____	___	___
10.	Has your child ever had a space maintainer, retainer, braces, orthodontic treatment or pain / tenderness in their jaw joint (TMJ)? Please explain. _____	___	___
11.	Was your child early, average, or late at getting his or her baby and/ or permanent teeth? _____	___	___
12.	Has your child had any unfavorable experiences in a dental or medical office? _____	___	___
13.	Do you consider your child to be high strung or generally nervous or hyperactive? _____	___	___
14.	How does your child react to any injury? _____	___	___
15.	How does your child behave around strangers? _____	___	___
16.	Has your child had a toothache recently? _____	___	___
17.	Is your child in pain now? _____	___	___
18.	Has your child had previous dental treatment? If so, when and where? _____ _____	___	___
19.	Do father and mother and child live together? If no, please explain. _____	___	___
20.	If you have previously completed this form for another child please give that child's name. _____	___	___

FOR BILLING AND INSURANCE PURPOSES,
PLEASE COMPLETE THE FOLLOWING INFORMATION IN FULL

Is your child covered by dental insurance? ___ Yes ___ No

FATHER: _____

MOTHER: _____

(Last) (First) (M.I.)
Natural Parent? ___ Yes ___ No

(Last) (First) (M.I.)
Natural Parent? ___ Yes ___ No

If no specify _____

If no specify _____

Home Address: _____

Home Address: _____

_____ Zip: _____

_____ Zip: _____

Home Phone : (____) _____

Home Phone : (____) _____

Work Phone : (____) _____

Work Phone : (____) _____

Cell Phone : (____) _____

Cell Phone : (____) _____

Father's Employer: _____

Mother's Employer : _____

Occupation : _____

Occupation : _____

Employer's Address : _____

Employer's Address : _____

City: _____ State: _____ Zip: _____

City: _____ State: _____ Zip: _____

Father's Social Security # _____

Mother's Social Security # _____

Father's Drivers License # _____

Mother's Drivers License # _____

Father's Date of Birth _____

Mother's Date of Birth _____

Name of Dental Insurance _____

Name of Dental Insurance _____

Policy # _____

Policy # _____

Insurance Phone # (____) _____

Insurance Phone # (____) _____

ALL ESTIMATES ARE GIVEN ACCORDING TO BENEFIT INFORMATION YOU HAVE PROVIDED TO OUR OFFICE. YOUR INSURANCE DOES NOT GUARANTEE PAYMENT AND BENEFITS ARE SUBJECT TO CHANGE WHEN CLAIMS ARE PROCESSED.

*****PRE-ESTIMATES ARE AVAILABLE UPON REQUEST.*****