

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 \_\_\_\_\_

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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 UNTIL 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.\*\*\***

