(C(0)11)3 We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime. **General Information Tell Us About Your Child** Who is accompanying the child today? Today's Date: Relation: ___ Child's Name: Last Do you have legal custody of this child? Yes No Whom may we Thank for referring you? ____ Child's Birthdate: ____/___/ Child's Age: ___ Nickname: _____ Male Female Other siblings: Previous / Present Dentist: Last Visit Date _____ Dentist's Phone #: (_____) ____ Hobbies: Relative or Friend not living with you: Name: Phone: (_____) ____ Child's Home Address: Address: ___ **Parent's Information** Person Responsible for Account: ______ Parent's Marital Status Single Married Partnered Widowed Divorced Separated **Mother** ☐ Step Mother ☐ Guardian ☐ **Father** ☐ Step Father ☐ Guardian _____/ Birthdate:____/___/ ____ Name: _____ Birthdate:___/___/___ Name: Address: (If different than Child's) Hm #: (____)___ Address: (If different than Child's) Hm #: (____) ____ SS #: _____ DL #: ____ 99 #: ______ DL #: _____ Wk #: (_____) ____ Ext: _____ Cell/Other #: (_____) ____ Email: ____ Employer: Employer's Address: Employer's Address: State State If you have Dental Insurance Coverage for the Child, please fill out below: If you have Dental Insurance Coverage for the Child, please fill out below: Insurance Co. Name: Insurance Co. Name: Insurance Address: Insurance Address: Insurance Phone: (____) Insurance Phone: (____)__ Group # (Plan, Local, or Policy #): Group # (Plan, Local, or Policy #):

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Dental History		Medical H	listory
Bemai misiory		Medical	ilisioi y
Why did you bring the child to the dentist today?		Has the child experienced the f N Abnormal Bleeding / Hemophilia N ADD/ADHD	i <mark>ollowing medical problems?</mark> Y N Heart Murmur Y N Hepatitis
Has the child ever taken any diet pills such as Phen-Fen? [Yes No	N AIDS/HIV+ N Anemia N Any Hospital Stays/Operations?	Y N High Blood Pressure Y N Hives
Does the child require antibiotics before dental treatment? Has the child ever had a serious/difficult problem associated with previous dental work? Is the child's water fluoridated? Is the child taking fluoridated supplements? Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Does the child brush his/her teeth daily?	Yes No Y Yes No Yes Yes	N Any Hospital Stays/Operations? N Artificial Bones/Joints/Valves N Asthma N Cancer N Chicken Pox N Congenital Heart Defect N Convulsions N Diabetes N Epilepsy N Exposed to HIV, but Neg. N Handicaps/Disabilities N Hearing Impairment	Y N Kidney Problems Y N Liver Problems Y N Low Blood Pressure Y N Lupus Y N Measles Y N Mitral Valve Prolapse Y N Mononucleosis Y N Prosthetics Y N Rheumatic Fever Y N Scarlet Fever Y N Skin Rash Y N Tuberculosis (TB)
Please describe the child's current physical health:	Yes No Plea	the child's immunizations current? thing you would like to discuss with the se discuss any serious medical problen	
Please list all prescription / over the counter or herbal supplement the child is currently taking: Aside from items listed, please list all drugs/things that the child is alle	ergic to:	5/did the child experience any of the fol N Breast Fed N Chewing on Objects N Clenching/Grinding Teeth N Lip Sucking/Biting N Mouth Breather	lowing? Y N Nursing Bottle Habits Y N Speech Problems Y N Thumb/Finger Sucking Y N Tongue/Cheek Biting Y N Tongue Thrust
Our office is HIPAA compliant and is committed to meeting of a laffirm that the information I have given is correct to the best of a office of any changes in my child's medical status. I authorize the d	ny knowledge. It will be h	neld in the strictest confidence and it is	s my responsibility to inform this
	Si	gnature of Parent or Guardian	Date
OFFICE USE ONLY OFFICE USE ONLY OFFICE	USE ONLY OFF	ICE USE ONLY OFFICE USE O	ONLY OFFICE USE ONLY
I have verbally reviewed the medical/dental information above with the Dentist's Comments:		atient named herein. Signature of Denti	ist Date
Ma	lical History	Undate	
Has there been any change in your child's health status since their last of Yes, please explain.		Parent/Guardian Signature Dentist Signature	Date Date
Has there been any change in your child's health status since their la			
If Yes, please explain.		Parent/Guardian Signature	Date