Why did you bring your child to the dentist today?

_____

Is this your child's first visit to the dentist? _____

If not, how long since the last visit. _____

Has your child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No If "yes", explain

_____

Does your child brush his or her teeth daily? ☐ Yes ☐ No

Floss his or her teeth daily? ☐ Yes ☐ No

Is your child's water fluoridated? ☐ Yes ☐ No

Is your child taking fluoride supplements ? ☐ Yes ☐ No

History of pain or tenderness in jaw joint? ☐ Yes ☐ No

Child's Physician: _____ Phone # _____

Is your child currently under the care of a physician?
☐ Yes ☐ No

Please describe your child's current physical health:
☐ Good ☐ Fair ☐ Poor

Please list all the drugs that your child is currently taking:

_____

Please list any drugs to which your child is allergic:

_____

Any history of angioedema, hereditary or other ?_____
If yes please explain._____

List any serious medical problems that your child has had:
_____

_____

Has your child ever had any of the following medical problems? (check box if yes)

- ☐ Abnormal Bleeding
- ☐ AIDS / HIV
- ☐ Allergy - Anesthetic
- ☐ Allergy- Latex Products
- ☐ Allergy to any Drugs
  _____
- ☐ Allergy – other
  _____
- ☐ Asthma
- ☐ Autistic
- ☐ ADD / ADHD
- ☐ Cancer, Type _____
- ☐ Congenital Heart Defect
- ☐ Convulsions/Epilepsy
- ☐ Diabetes
- ☐ Any hospital stays
  _____
- ☐ Any operations
  _____
- ☐ Hemophilia
- ☐ Hepatitis, Type_____
- ☐ Hearing Impairment
- ☐ Hemophilia
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Kidney / Liver Problems
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Speech Impairment
- ☐ Tuberculosis (TB
- ☐ Handicaps/Disabilities
- ☐ Other
  _____
  _____

Does your child have any of the following habits?

- ☐ Thumb / Finger Sucking
- ☐ Lip Sucking / Biting
- ☐ Nail Biting
- ☐ Nursing Bottle Habits

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and that is is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

_____ _____
Signature of Parent or Guardian Date

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

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.

chesterfield hilltown dental

Tell Us About Your Child

Today's date: _____

Child's Name: _____
Last First MI

Nickname: _____ ☐Male ☐Female

Child's Birthdate: _____ Child's Age:_____

School: _____ Grade: _____

Child's Home #: _____ SS #: _____

Child's Home Address:

_____

_____

Who is accompanying child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐Yes ☐ No

Who may we thank for referring you? _____

Previous/Present Dentist: _____ Last Visit _____

Mother's Information (☐Step Mother ☐Guardian)

Name: _____DOB:_____

Address:_____

WK#: _____ Ext: _____ HM#: _____

Employer: _____SS#:_____

Father's Information (☐Step Father ☐Guardian)

Name: _____DOB:_____

Address:_____

WK#: _____ Ext: _____ HM#: _____

Employer: _____SS#: _____

Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____

WK#: _____ Ext _____ HM#: _____

Employer: _____

Who is responsible for making appts?

Name: _____

WK#: _____ Ext _____ HM# _____

Primary Dental Insurance

Insurance Co Name: _____

Insurance Co Address: _____

Insurance Co Phone: _____ Group #:_____

Subscriber's Name: _____

Relationship to Patient: _____

Subscriber's Birthday: _____ SS#: _____

Subscriber's Employer: _____

Secondary Dental Insurance

Insurance Co Name: _____

Insurance Co Address: _____

Insurance Co Phone: _____ Group #:_____

Subscriber's Name: _____

Relationship to Patient: _____

Subscriber's Birthday: _____ SS#: _____

Subscriber's Employer: _____