



Welcome to our practice!

We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child good oral habits, which will keep their smile beautiful for their lifetime.

<p>Child's Name</p> <hr/> <p>Last First MI</p> <p>Child's Nickname _____</p> <p>Child's Birth date _____ Age _____ Sex _____</p> <p>Home Address _____</p> <p>City _____ Zip _____</p> <p>Home Phone # _____</p> <p>Cell Phone # _____</p> <p>Alternate Contact _____ Phone _____</p> <p>Names of other children in family _____</p> <p>Referred by _____</p>	<p>Parent / Guardian information</p> <p>Name _____</p> <p>Relationship _____</p> <p>Home Address _____</p> <p>City _____ Zip _____</p> <p>Home Phone# _____ Cell _____</p> <p>SSN# _____ DOB _____</p> <p>Employer _____</p> <p>Work Phone # _____</p> <p>Email Address _____</p> <p>Parent's Marital Status: Married Divorced Separated Widowed Single Remarried</p>
<p>Primary Dental Insurance</p> <p>CO Name _____</p> <p>Address _____</p> <p>Phone# _____ Insured ID# _____</p> <p>Group# _____ Insured's Name _____</p> <p>Relation _____ DOB _____</p> <p>Insured Employer _____</p> <p>SSN# _____</p>	<p>Secondary Dental Insurance</p> <p>CO Name _____</p> <p>Address _____</p> <p>Phone# _____ Insured ID# _____</p> <p>Group# _____ Insured's Name _____</p> <p>Relation _____ DOB _____</p> <p>Insured Employer _____</p> <p>SSN# _____</p>

Child's Physician _____

City/State _____ Phone# _____

Date of last exam _____ Results _____

Health History

Has your child ever had any of the following:

- AIDS/HIV _____
- Anemia _____
- Asthma _____
- Autism _____
- Bladder Problems _____
- Cancer _____
- Cerebral Palsy _____
- Congenital Birth Defects _____
- Convulsions/Fainting _____
- Diabetes _____
- Epilepsy _____
- Eating Disorder _____
- Speech/Hearing Problems _____
- Heart Problems/Murmur _____
- Hepatitis _____
- Mouth Breather _____
- Pregnant _____
- Prolonged Bleeding/Bruises easily _____
- Psychological/Emotional Problems _____
- Rheumatic Fever _____
- Sinus Problems _____
- Tuberculosis _____
- Allergies _____

Do you consider your child to be _____

Advanced in the learning process _____

Progressing normally _____

Slow in the learning process _____

Please explain any medical problems your child has/had or any medications currently taking _____

Date of the last dental visit _____

Previous Dentist _____

Has your child had any difficulty with previous dental visits? _____

Have there been any injuries to teeth, face, or mouth? _____

Why did you bring your child to the dentist today? _____

Is your child breastfed? Yes/No Until what age _____

Does your child still take a bottle or a sippy cup?
Yes/No

What is your child's favorite fluid to drink? Water,
Kool-aid, Apple juice, Other Juice, Milk, Formula,
Tea, Soft drink, Sports drinks, or other

How often does your child brush? _____

Do you help w/ brushing? _____

How often does your child floss? _____

Is child's water fluoridated? _____

Does your child:

Suck thumb or finger _____

Bite/suck lips _____

Bite/chew nails _____

Grind teeth _____

Clench jaws _____

Chew hard objects _____

Use a pacifier _____

Parent/Guardian Signature and date _____
