PRIMARY DENTAL INSURANCE

Today's Date: _____

Child's Name: _____
Last First

Nickname: _____ ()male ()female

Birthday: ___/___/___ Age: _____

SS#: _____

Home Address: _____

_____Zip Code: _____

Phone #: _____

School: _____ Grade: _____

WHO IS ACCOMPANYING CHILD TODAY

Name: _____

Relationship: _____

Do you have legal custody of child? ____

Previous/Present Dentist: _____

Parents Marital Status: _____

MOTHER'S INFORMATION

Name: _____

Work #: _____ Ext: _____

Employer: _____

SS#: _____

DL#: _____

FATHER'S INFORMATION

Name: _____

Work #: _____ Ext: _____

Employer: _____

SS#: _____

DL#: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Billing Address: _____

_____

Work #: _____ Ext: _____

Home #: _____

Payment is due in full at the time Of treatment unless prior arrangements have been approved. If this account is placed for collection, I agree to pay all collection fees or court costs and attorney fees.

_____Signature/Date

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group/Plan #: _____

Insured's Name: _____

Relationship:_____

Insured's Birthday: ___/___/___

Insured's SS#: _____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group/Plan #: _____

Insured's Name: _____

Relationship: _____

Insured's Birthday: ___/___/___

Insured's SS#: _____

Insured's Employer: _____

WHY DID YOU BRING THE CHILD TODAY?

Has the child ever had a serious or difficult problem with dental work?

Is your water fluorinated?

Is the child taking fluoride supplements?

Has the child ever had any pain or tenderness in their jaw joint (TMJ/TMD)?

Does the child brush their teeth daily?

Does the child floss their teeth daily?

Does the child have 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. Therefore there will be a sterilization barrier protection fee charge per visit. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? Yes No
If so, for what condition? _____

Doctor's Name	Treatment	Date

List all medications taken in the last six months: _____
_____

Are you sensitive or allergic to any medicines? (penicillin, aspirin, codeine, iodine, erythromycin, tetracycline, epinephrine, cephalosporins, clindamycin) Others: _____
_____

Are you sensitive or allergic to any metals? Yes No
Women only: Are you pregnant? Yes No
Do you anticipate becoming pregnant? Yes No
Are you taking birth control pills? Yes No

Has a physician ever told you that you need to be pre-medicated prior to dental treatment, due to a medical condition? Yes No

Please circle any of the following conditions which you have been diagnosed with by a physician

Cardiovascular (Heart)

Heart Murmur
Rheumatic Fever
Mitral Valve Prolapse
Artificial Heart Valve
High or Low Blood Pressure
Heart Failure
Heart Disease or Attack
Angina Pectoris
Heart Pacemaker
Heart Surgery, when _____
None Known

Kidney and Liver

Liver Disease
Kidney Trouble
Excessive Bleeding
Hepatitis
Jaundice
GI Disorder

Miscellaneous

Artificial Joints, Pins, Screws
Cancer or Tumor, if so type _____
Leukemia
Chemotherapy or Radiation Therapy, Date of Last Treatment _____
Anemia
Epilepsy or Seizures
Emphysema
Tuberculosis
AIDS, HIV, or ARC
Diabetes
Ulcers
Asthma
Sinus Trouble
Thyroid Disease
Arthritis
Psychiatric treatment (ex: depression, anxiety…)
Hemophilia
Venereal Diseases (syphilis, gonorrhea, genital herpes)
Organ Removal or Transplant, if so which one _____
Glaucoma
Prostate/Urinary Tract
Temporomandibular Dysfunction (TMJ)

To the best of my knowledge, all of the preceding answers are true and correct. If I have any changes in my health or medications, I will notify my dentist at the next appointment.

_____ _____ _____
Signature of Patient, Parent, Guardian Date Signature of Dentist

Medical History Update:
_____
_____
_____
_____
_____
_____