



WELCOME



Tell us about your child

Today's Date: _____

Child's Name: _____

Birthdate: ___/___/___ Child's Age: _____

Preferred Name: _____ Male Female

Child's Home #: _____

Child's Home Address: _____

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No

Is the child adopted? Yes No

Is the child in a foster home? Yes No

Whom may we thank for referring you? _____

Other siblings seen by us: _____

Previous/Present Dentist: _____

Last Visit Date: _____

Parental Information

Mother Step Mother Guardian

Father Step Father Guardian

Name: _____

Name: _____

Birthdate: ___/___/___ Home # _____

Birthdate: ___/___/___ Home # _____

Work # _____ Cell # _____

Work # _____ Cell # _____

SS#: _____ Occupation: _____

SS#: _____ Occupation: _____

E-Mail: _____

E-Mail: _____

Parent's Marital Status: Single Married Divorced Widowed Partnered Separated

Primary Dental Insurance

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___

Policy Owner's SS#: _____

Insurance Co. Name: _____

Insurance Policy ID #: _____

Policy Owner's Employer: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Insurance Co. Group #: _____

Secondary Dental Insurance

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___

Policy Owner's SS#: _____

Insurance Co. Name: _____

Insurance Policy ID #: _____

Policy Owner's Employer: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Insurance Co. Group #: _____

I certify that my child is covered by the above Insurance Co. and I assign directly to the Tootharium all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of parent or guardian

Date

Why did you bring the child to the dentist today?

Has your child ever had a serious/difficult problem associated with previous dental work? **Y N**

If yes, please explain: _____

Is the child's water fluoridated? **Y N**

Is the child taking fluoridated supplements? **Y N**

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? **Y N**

Does the child brush his/her teeth daily? **Y N**

Floss his/her teeth daily? **Y N**

Has the child ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? **Y N**

Child's Physician: _____

Phone # _____ Date of last visit: _____

Please describe the child's current physical health:

Good Fair Poor

Please list all medications the child is currently taking:

Aside from items listed below, list all medications/ things the child is allergic to: _____

Latex **Y N** Metals/Nickel **Y N** Plastic **Y N**

Has the child ever had any of the following medical problems? If yes, explain below.

- | | |
|---|---------------------------------------|
| Y N Abnormal Bleeding | Y N Handicaps/Disabilities |
| Y N ADD/ADHD | Y N Hearing/Vision Loss |
| Y N Anemia | Y N Heart Murmur |
| Y N Any Hospital Stays | Y N Hemophilia |
| Y N Any Operations | Y N Hepatitis |
| Y N Artificial Bones/Joints/Valves | Y N Hives |
| Y N Asthma | Y N HIV+/AIDS |
| Y N Autism/Asperger's/PDD | Y N Kidney/Liver Problems |
| Y N Cancer | Y N Measles |
| Y N Chicken Pox | Y N Mononucleosis |
| Y N Congenital Heart Defect | Y N Rheumatic/Scarlet Fever |
| Y N Convulsions | Y N Sensory Issues |
| Y N Diabetes | Y N Sickle Cell Disease/Traits |
| Y N Epilepsy | Y N Skin Rash |
| Y N Exposed to HIV, but Neg. | Y N Tuberculosis(TB) |

Are the child's immunizations current? **Y N**

Anything you would like to discuss with the doctor in private? **Y N**

Does /did the child have any of the following habits?

- | | |
|-------------------------------|----------------------------------|
| Y N Lip Sucking/Biting | Y N Nursing Bottle Habits |
| Y N Nail Biting | Y N Thumb/Finger Sucking |

Was the child breast fed? **Y N**

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 it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian

Date

I understand that I am responsible for any balance incurred either after insurance pays or without insurance.

Signature of parent or guardian

Date