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: ________________________

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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

Name: __________________________________

Birthdate: ____/____/____ Home # _____________

Work # ______________ Cell # _______________

SS#: __________________ Occupation: _________

E-Mail: _________________________________

☐ Father ☐ Step Father ☐ Guardian

Name: __________________________________

Birthdate: ____/____/____ Home # _____________

Work # ______________ Cell # _______________

SS#: __________________ Occupation: _________

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: _______________________

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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: _______________________

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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.

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Signature of parent or guardian Date

Why did you bring the child to the dentist today?

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

If yes, please explain: ___________________________

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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

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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.

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Signature of parent or guardian Date

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

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Signature of parent or guardian Date