CHILDREN'S DENTAL WORLD
smiles in any language

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach oral care that will enable your child to have a beautiful smile that lasts a lifetime!

Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

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

Nickname: _____ Male ____ Female ____

School: _____ Grade: _____

Child's Home Phone #: _____

Child's Home Address: _____

_____

_____
City State Zip

General Information

Who is accompanying the child today? _____

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

How did you hear about our office? _____

Other sibling(s) seen by us: _____

Previous/Present Dentist: _____ Last Visit Date: _____

Dentist's Phone #: _____

Relative or Friend not living with you:

Name: _____ Phone: _____

Address: _____

_____
City State Zip

Parents' Information

Person responsible for account: _____

____ Father ____ Stepfather ____ Guardian

Name: _____ Birthdate: ___/___/___

Address: (if different than Child's) Home #: _____

_____

_____

SS #: _____

Work #: _____ Ext: ___ Cell #: _____

Email: _____

Employer: _____

Parents' Martial Status: ____ Single ____ Married ____ Widowed ____ Divorced ____ Separated

____ Mother ____ Stepmother ____ Guardian

Name: _____ Birthdate: ____/____/_____

Address: (if different than Child's) Home #: _____

_____

_____

SS #: _____

Work #: _____ Ext: ____ Cell #: _____

Email: _____

Employer: _____

Release

I certify that my child is covered by _____ Insurance Co. and I assign 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 benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of Parent or Guardian Date

Dental & Medical History

Why did you bring your child to the dentist today?

_____

_____

_____

Is your child currently in pain? ___Yes ___No

How often does your child brush his/her teeth daily? ___

What type of toothpaste does he/she use?

__with Fluoride __Fluoride free (toddler) __Don't know

Does your child floss his/her teeth daily? ___Yes ___No

Is child currently under care of a physician? __Yes __No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Please list all prescription/over the counter or herbal supplement drugs that the child is currently taking:

_____

_____

_____

Is your child allergic to any of the following? __Yes __No

____ Latex ____ Metal/Nickel

____ Penicillin ____ Other- Please list: _____

_____

_____

Has your child experienced the following medical problems?

Y	N	ADD /ADHD	Y	N	Hepatitis
Y	N	AIDS/HIV Positive	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV Exposure (but negative)
Y	N	Artificial Heart Valve	Y	N	Hives or Rash
Y	N	Artificial Joint	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Measles
Y	N	Autism	Y	N	Mitral Valve Prolapse
Y	N	Cancer	Y	N	Mononucleosis
Y	N	Chemotherapy	Y	N	Psychiatric Care
Y	N	Chicken Pox	Y	N	Rheumatic Fever
Y	N	Congenital Heart Defect	Y	N	Scarlet Fever
Y	N	Developmental Delays	Y	N	Sensory Processing Disorder
Y	N	Diabetes	Y	N	Sickle Cell Disease
Y	N	Epilepsy or Seizure	Y	N	Speech Delays
Y	N	Excessive Bleeding	Y	N	Tonsillitis
Y	N	Handicaps	Y	N	Tuberculosis
Y	N	Hearing Impaired	Y	N	Tumors
Y	N	Heart Murmur	Y	N	Ulcers

Has your child had any illness not listed above?

____ No

____ Yes (please list) _____

Is the child's immunizations current? ____Yes ____No

Has your child ever had to stay in the hospital or had an operation?

____ No

____ Yes (please list) _____

Does your child currently:

Y	N	Breast Feed	Y	N	Sleep with Sip Cup
Y	N	Clench/Grind Teeth	Y	N	Take Gummy Vitamins
Y	N	Drink Tap Water	Y	N	Thumb/Finger Suck
Y	N	Sleep with a Bottle	Y	N	Use a Pacifier

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

I affirm that the information I have given is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health, and it is my responsibility to inform the dental office of any changes in medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent or Guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.