WELCOME!

Tell us about your child: Date: ______________
Child's Name: ______________ Sex: M ◯ F ◯ SS#: ______________
Nickname: ______________ Birthdate: ______________ Home Phone#: ______________
Address: ______________
School: ______________ Hobbies/Interests: ______________

Who is accompanying the child today?
The Parent/Guardian who accompanies the child is responsible for payment at time of services.
Name: Relation:
Do you have legal custody of the child? Y ◯ N ◯ Is the child adopted? Y ◯ N ◯
Is the child living in a foster home? Y ◯ N ◯
Who may we thank for referring you? ______________ Other siblings seen by us: ______________

Parent's Information:
Mother ◯ Stepmother ◯ Guardian ◯
Name: ______________ SS#: ______________ Birthdate: ______________
Address: ______________ Home #: ______________
Employer: ______________ Work #: ______________

Father ◯ Stepfather ◯ Guardian ◯
Name: ______________ SS#: ______________ Birthdate: ______________
Address: ______________ Home #: ______________
Employer: ______________ Work #: ______________

Person Responsible for Account:
Name: ______________ Relation: ______________ SS#: ______________
Address: ______________ Home #: ______________
Employer: ______________ Work #: ______________

Person Responsible or Making Appointments:
Name: ______________ Home #: ______________ Work #: ______________

Primary Dental Insurance:
Insurance Company Name: ______________
Ins. ID# ______________
Ins. Phone #: ______________ Group #: ______________
Ins. Address: ______________
Subscriber's Name: ______________
Relations to patient: ______________
Sub DOB ______________ Sub SS# ______________
Sub Employer ______________
Employer's Address: ______________

Secondary Dental Insurance:
Insurance Company Name: ______________
Ins. ID# ______________
Ins. Phone #: Group #: ______________
Ins. Address: ______________
Subscriber's Name: ______________
Relations to patient: ______________
Sub DOB ______________ Sub SS# ______________
Sub Employer ______________
Employer's Address: ______________

Dental History
Why did you bring your child to the dentist today? ______________
Has your child ever had a serious/difficult problem associated with previous dental work? Yes ◯ No ◯
Is your child's water fluoridated? Yes ◯ No ◯ Is your child taking fluoride supplements? Yes ◯ No ◯
Has you child even had an pain/tenderness in his/her jaw joint (TMJ)? Yes ◯ No ◯
Has anyone in your child's family has missing or extra teeth? Yes ◯ No ◯ If yes, who? ______________
Rate your child's dental health: Excellent ◯ Good ◯ Fair ◯ Poor ◯ When did you child's first tooth erupt? ______________
Does/did your child have any of the following habits? Lip sucking/biting ◯ Nail biting ◯ Nursing Bottle habits ◯
Thumb/finger sucking ◯ Grinding teeth ◯ Pacifier ◯
Was/is your child breastfed? Yes ◯ No ◯ Until what age: ______________ Bottle-fed until what age:
Previous/Present Dentist: ______________ Last Visit Date: ______________
Were x-rays taken? Yes ◯ No ◯ Does your child brush daily? Yes ◯ No ◯ Floss? Yes ◯ No ◯

Medical History

Childs Physician: ____________________ **Phone#:** __________

Address: ____________________

Is your child currently under the care of a physic Y ◯ N ◯ If yes, explain ____________________

Please describe your child's current physical condition: Good ◯ Fair ◯ Poor ◯

Are immunizations current? Y ◯ N ◯

Please list all medications that your child is currently taking: ____________________

Please list all allergies that your child has, including medications, food and environmental: ____________________

Is your child latex sensitive? Y ◯ N ◯ Is your child allergic to any metals? Y ◯ N ◯ If so, please list: ____________________

Has your child had/experienced any of the following? Indicate each with a check mark:

Y ◯ N ◯ Abnormal Bleeding	Y ◯ N ◯ Cancer	Y ◯ N ◯ Hemophilia	Y ◯ N ◯ Mumps
Y ◯ N ◯ Accidents	Y ◯ N ◯ Chicken Pox	Y ◯ N ◯ Hepatitis	Y ◯ N ◯ Patent
Y ◯ N ◯ AIDS/HIV Positive	Y ◯ N ◯ Congenital Birth Defect	Y ◯ N ◯ Herpes	Y ◯ N ◯ Psychiatric Trtmnt
Y ◯ N ◯ Anemia	Y ◯ N ◯ Congenital Heart Defect	Y ◯ N ◯ High Blood Pressure	Y ◯ N ◯ Rheumatic Fever
Y ◯ N ◯ Any Hospital Stays	Y ◯ N ◯ Convulsions	Y ◯ N ◯ Hives	Y ◯ N ◯ Scarlet Fever
Y ◯ N ◯ Any Operations	Y ◯ N ◯ Developmental Delays	Y ◯ N ◯ Jaundice	Y ◯ N ◯ Seizures
Y ◯ N ◯ Arthritis	Y ◯ N ◯ Diabetes	Y ◯ N ◯ Joint Replacements	Y ◯ N ◯ Shunts
Y ◯ N ◯ Asperger's Syndrome	Y ◯ N ◯ Epilepsy	(Pins/Rods/Implants)	Y ◯ N ◯ Significant Injuries
Y ◯ N ◯ Asthma	Y ◯ N ◯ Endocrine System Prob	Y ◯ N ◯ Kidney Problems	Y ◯ N ◯ Sickle Cell Anemia
Y ◯ N ◯ Autism	Y ◯ N ◯ Exposed to HIV but neg	Y ◯ N ◯ Liver Problems	Y ◯ N ◯ Skin Rash
Y ◯ N ◯ Behavioral/Learning Prob.	Y ◯ N ◯ Fainting Spells	Y ◯ N ◯ Low Blood Pressure	Y ◯ N ◯ Tonsillitis
Y ◯ N ◯ Blood Transfusion	Y ◯ N ◯ Frequent Infection	Y ◯ N ◯ Lupus	Y ◯ N ◯ Tuberculosis
Y ◯ N ◯ Blood Disorder	Y ◯ N ◯ Handicaps/Disabilities	Y ◯ N ◯ Measles	Y ◯ N ◯ Typhoid Fever
Y ◯ N ◯ Broken Bones/Fractures	Y ◯ N ◯ Hearing Impairments	Y ◯ N ◯ Mitral Valve Prolapse	Y ◯ N ◯ Vision Problems
	Y ◯ N ◯ Heart Murmur	Y ◯ N ◯ Mononucleosis	Y ◯ N ◯ Ventral Septal Defect

If you answered yes to any of the above, please explain: ____________________

If your child has any other health problems not listed above, please list and explain: ____________________

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest of 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 Signature: ____________________ **Date:** __________

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

Signature: ____________________ **Date:** __________

Office use: I have verbally reviewed the medical/dental information above with the parent/guardian. Initials: __________

Doctor's Comments: ____________________ **Date:** __________