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:	Secondary Dental Insurance:
Insurance Company Name: ____________	Insurance Company Name: ____________
Ins. ID# ____________	Ins. ID# ____________
Ins. Phone #: ____________ Group #: ____________	Ins. Phone #: ____________ Group #: ____________
Ins. Address: ____________	Ins. Address: ____________
Subscriber's Name: ____________	Subscriber's Name: ____________
Relations to patient: ____________	Relations to patient: ____________
Sub DOB ____________ Sub SS# ____________	Sub DOB ____________ Sub SS# ____________
Sub Employer ____________	Sub Employer ____________
Employer's Address: ____________	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 physician (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	PAD
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 n 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: ____________