W	e	С	O	m	e!	A CH
		Tell Us About	Your Child			-

	Today's Date:	Child's Home	Phone #: ()	Social Security #:		
7	Child's Name:				Child's Birthdate:/	_/ Child's Age:	
-	Nickname:	D Ma	First ale 🖵 Female	School:	MI	Grade:	
	Child's Home Address:						
/	Whom may we thank for referrin	Street g you?			City	State	Zip
-	Email Address:						

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Name:	Social Secu	urity #:	Driver	s License #:	
Birthdate:/ Home Phon					
Email Address:			Cell #: ()		
Address:					
Street Street			City Length o		ip
Parent: 🗆 Father 🗆 Mother 🗆 Step					
Name:	Social Secu	urity #:	Driver	s License #:	
Birthdate:/ Home Phon	e #: ()		Work Phone #: ()	
Email Address:			Cell #: ()		/
Address:			City		-
Employer:				Employment:	ip
	Insura	ance Info	rmation		
Primary Insurance Dental Coverage?				Medical Coverage?	Yes 🖬 No
Insurance Co. Name:	□ Yes □ No Phone #: (Orthodontic C	overage? 🗆 Yes 💷 No		
Insurance Co. Name:	□ Yes □ No Phone #: (Orthodontic C	Coverage?	cal, or Policy #):	
Insurance Co. Name: Insurance Co. Address: PO Box/Stree	□ Yes □ No Phone #: (Orthodontic C	Coverage? Yes No Group # (Plan, Log	cal, or Policy #):	
Insurance Co. Name: Insurance Co. Address: PO Box/Stree Insured's Name:	□ Yes □ No Phone #: (Orthodontic C	Coverage? Yes No Group # (Plan, Log City Relationship to Patient:	cal, or Policy #): State	Zīp
Insurance Co. Name: Insurance Co. Address: Insured's Name: Insured's Birthdate:// Insured Employer's Address:	□ Yes □ No Phone #: (Orthodontic C	Coverage? Yes No	cal, or Policy #): State	Zip
Insurance Co. Name: Insurance Co. Address: Insured's Name: Insured's Birthdate:/ Insured Employer's Address: Street	Yes No Phone #: [' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	Orthodontic C	Coverage? Yes No Group # (Plan, Lou City Relationship to Patient: Insured's Employer: City City	cal, or Policy #): State	Zip
Insurance Co. Name: Insurance Co. Address: Insured's Name: Insured's Birthdate:/ Insured Employer's Address: Street Secondary Insurance Dental Coverage	Yes No Phone #: (Orthodontic C	Coverage? Yes No Group # (Plan, Log City Relationship to Patient: Insured's Employer: City City City Coverage? Yes No	State State Medical Coverage?	Zip Zip 2 Yes No
Insurance Co. Name: Insurance Co. Address: Insured's Name: Insured's Birthdate:/ Insured Employer's Address: Street Secondary Insurance Dental Coverag Insurance Co. Name:	Yes No Phone #: (Orthodontic C	Coverage? Yes No Group # (Plan, Log City Relationship to Patient: Insured's Employer: City City City Coverage? Yes No	State State Medical Coverage?	Zip Zip 2 Yes No
Secondary Insurance Dental Coverage Insurance Co. Name: Insurance Co. Address: PO Box/Stree	Yes No Phone #: (Orthodontic C	Coverage? Yes No Group # (Plan, Log City Relationship to Patient: Insured's Employer: City City Coverage? Yes No Group # (Plan, Log City City	State State Medical Coverage? Cal, or Policy #): State	Zip Zip 2 Yes No
Insurance Co. Name: Insurance Co. Address: Insured's Name: Insured's Birthdate:/ Insured Employer's Address: Street Secondary Insurance Dental Coverag Insurance Co. Name: Insurance Co. Address: Insurance Co. Address:	Yes No Phone #: [Ys ID #: ge? Yes No Phone #: [Orthodontic C	Coverage? Yes No	State State Medical Coverage? Cal, or Policy #):	Zip Zip 2 Yes No Zip
Insurance Co. Name: Insurance Co. Address: Insured's Name: Insured's Birthdate:/ Insured Employer's Address: Street Secondary Insurance Dental Coverag Insurance Co. Name: Insurance Co. Address: PO Box/Street	Yes No Phone #: [Ys ID #: ge? Yes No Phone #: [Orthodontic C	Coverage? Yes No	State State Medical Coverage? Cal, or Policy #):	Zip Zip 2 Yes No Zip

CONTINUED ON BACK

5	Has the child experienced problems Does the child brush his / her teeth Floss his / her teeth daily?	daily?	Yes 🗆 No Yes 🗆 No Yes 💷 No			>
						1
	Floss his / her teeth daily?					
				Date of Last Visit)
-1	Previous / Present Dentist: (Please Circle)		L	Date of Last Visit		5
11	Why did you leave your previous der	ntist?				5
	What did you like most about any de	entist you have seen?		Least?		3
5						Z
-> (Does / did the child have any of			(0) 1.85	V N N I D I	
	Y N Lip Sucking/Biting					1
F	Y N Nail Biting Y N Chewing on Objects	Y N Thumb/Finger Sucking Y N Nursing Bottle Habits	~		Y N Speech Problems Y N Breast Fed	1
5 11	T IN Chewing on Objects	T IN INUISING DOMIC Habits	1 19 10	ongue infusi	T IN DIEdsi red	
			-			
5		Medica	l History			
	Child's Physician:		:()	Date of last	visit:	
-	Address:		1 15	Date of last		Y
3	Address:Street	Phone #	City		State Zip	X
\Rightarrow	Address:	Phone #: of a physician? Ves No Ple	City case explain:		State Zip	X
7	Address:	of a physician? • Yes • No Ple ent physical health: • Good	City case explain:		State Zip	7
Z	Address:	of a physician? Yes No Ple ent physical health: Good urrently taking:	City ase explain: I Fair I Poor	Are Immunizatio	State Zip	7
R	Address: Street Is the child currently under the care of Please describe the child's currently Please list all drugs that the child is cu Besides the following, please list all of	of a physician? I Yes I No Ple ent physical health: Good urrently taking: drugs and/or things that cause the	City asse explain: Fair Poor child allergic read	Are Immunization	State Zip	7
R	Address:	of a physician? I Yes I No Ple ent physical health: Good urrently taking: drugs and/or things that cause the	City asse explain: Fair Poor child allergic read	Are Immunization	State Zip	7
R	Address: Street Is the child currently under the care of Please describe the child's currently Please list all drugs that the child is cu Besides the following, please list all of	of a physician? I Yes I No Ple ent physical health: Good urrently taking: drugs and/or things that cause the	City asse explain: Fair Poor child allergic read	Are Immunization	State Zip	A JA
	Address:	of a physician? • Yes • No Ple ent physical health: • Good currently taking: drugs and/or things that cause the ckel • Yes • No Plastic? • Ye	City ease explain: Fair Poor child allergic reac s No Penic	Are Immunization	State Zip	7
	Address: Street Is the child currently under the care of Please describe the child's currently Please list all drugs that the child is cu Besides the following, please list all of	of a physician? • Yes • No Ple ent physical health: • Good urrently taking: drugs and/or things that cause the skel • Yes • No Plastic? • Yes ith the Doctor in private? • Yes • 1	City ease explain: Fair Poor child allergic read s No Penici No	Are Immunizations:	State Zip ns Current? Yes No Tetracycline? Yes No	T A
	Address:	of a physician? • Yes • No Ple ent physical health: • Good urrently taking: drugs and/or things that cause the skel • Yes • No Plastic? • Yes ith the Doctor in private? • Yes • 1	City ease explain: Fair Poor child allergic reac s No Penic	Are Immunizations:	State Zip ns Current? Yes No Tetracycline? Y N Mitral Valve Prolapse	T A
	Address:	Phone #: of a physician? • Yes • No Ple rent physical health: • Good urrently taking: drugs and/or things that cause the ckel • Yes • No Plastic? • Yes ith the Doctor in private? • Yes • 1 I any of the following:	City ease explain: Fair Poor child allergic read s No Penici No No Y N Hem Y N Hem	Are Immunization ttions: illin? □ Yes □ No nophilia atitis	State Zip ns Current? Yes No Tetracycline? Yes No	T A
	Address:	Phone #: of a physician? Pes No Ple rent physical health: Good urrently taking: drugs and/or things that cause the ckel Yes No Plastic? Ye ith the Doctor in private? Yes I any of the following: Y N Cancer	City case explain: Fair Poor child allergic read s No Penici No Y N Hem Y N Hep t Y N High	Are Immunization tions: illin? □ Yes □ No nophilia atitis n Blood Pressure	State Zip ns Current? Yes No Y N Mitral Valve Prolapse Y N Mononucleosis Y N Rheumatic Fever	T A
	Address:	of a physician? I Yes I No Ple ent physical health: Good urrently taking: drugs and/or things that cause the ckel Yes No Plastic? Ye ith the Doctor in private? Yes I any of the following: Y N Cancer Y N Chicken Pox	City ease explain: Fair Poor child allergic reac s No Penici No No Y N Hem Y N Hep Y N High Y N High Y N Hive	Are Immunization tions: illin? • Yes • No nophilia atitis n Blood Pressure as	State Zip ns Current? Yes No Tetracycline? Yes No Y N Mitral Valve Prolapse Y N Mononucleosis Y N Rheumatic Fever Y N Scarlet Fever	T A
	Address:	of a physician? I Yes I No Ple rent physical health: Good urrently taking: drugs and/or things that cause the skel Yes No Plastic? Yes ith the Doctor in private? Yes I any of the following: Y N Cancer Y N Cancer Y N Chicken Pox Y N Congenital Heart Defect Y N Convulsions Y N Diabetes	City ease explain: Fair Poor child allergic reac s No Penici No Y N Hem Y N Hep t Y N High Y N Hive Y N Hive Y N Kidn	Are Immunization tions: illin? • Yes • No nophilia atitis n Blood Pressure is ney Problems	State Zip ns Current? Yes No Tetracycline? Yes No Y N Mitral Valve Prolapse Y N Mononucleosis Y N Rheumatic Fever Y N Scarlet Fever Y N Sickle Cell Anemia	T A
	Address:	of a physician? I Yes I No Ple Yent physical health: Good urrently taking: drugs and/or things that cause the ckel Yes No Plastic? Yes ith the Doctor in private? Yes I any of the following: Y N Cancer Y N Chicken Pox Y N Congenital Heart Defect Y N Convulsions Y N Diabetes Y N Epilepsy	City case explain: Fair Poor child allergic reac s No Penici No Y N Hem Y N Hem Y N High Y N Hive Y N Kidn Y N Liver	Are Immunization tions: illin? I Yes I No nophilia atitis n Blood Pressure is ney Problems r Problems	State Zip Ins Current? Yes No Tetracycline? Yes No Y N Mitral Valve Prolapse Y N Mononucleosis Y N Rheumatic Fever Y N Scarlet Fever Y N Sickle Cell Anemia Y N Skin Rash	T A
	Address:	Phone # of a physician? Yes No Ple rent physical health: Good currently taking: drugs and/or things that cause the ckel Yes No Plastic? Yes ith the Doctor in private? Yes I any of the following: Y N Cancer Y N Concer Y N Congenital Heart Defect Y N Convulsions Y N Diabetes Y N Epilepsy Y N Handicaps/Disabilities	City case explain: Fair Poor child allergic reactions No Y N Hem Y N Hem Y N Hep Y N Hive Y N Hive Y N Kidn Y N Liver Y N Low	Are Immunization ttions: illin? • Yes • No nophilia atitis n Blood Pressure ts r Problems r Problems Blood Pressure	State Zip ns Current? Yes No Tetracycline? Yes No Y N Mitral Valve Prolapse Y N Mononucleosis Y N Rheumatic Fever Y N Scarlet Fever Y N Sickle Cell Anemia Y N Skin Rash Y N Tonsillitis	T A
	Address:	of a physician? I Yes I No Ple Yent physical health: Good urrently taking: drugs and/or things that cause the skel I Yes No Plastic? Yes I tany of the following: Y N Cancer Y N Concer Y N Concer Y N Concerital Heart Defect Y N Convulsions Y N Diabetes Y N Epilepsy Y N Handicaps/Disabilities Y N Hearing Impairment	City ease explain: Fair Poor child allergic reac s No Penici No Y N Hem Y N High Y N Hive Y N Hive Y N Kidn Y N Liver Y N Low Y N Low Y N Low	Are Immunization ttions: illin? • Yes • No nophilia atitis n Blood Pressure is rev Problems r Problems Blood Pressure JS	State Zip Ins Current? Yes No Tetracycline? Yes No Y N Mitral Valve Prolapse Y N Mononucleosis Y N Rheumatic Fever Y N Scarlet Fever Y N Sickle Cell Anemia Y N Skin Rash	T A
	Address:	of a physician? I Yes I No Ple Yent physical health: Good urrently taking: drugs and/or things that cause the ckel Yes No Plastic? Yes ith the Doctor in private? Yes I any of the following: Y N Cancer Y N Concer Y N Congenital Heart Defect Y N Convulsions Y N Diabetes Y N Epilepsy Y N Hearing Impairment Y N Heart Murmur	City asse explain: Fair Poor child allergic read s No Penici No Y N Hem Y N Hem Y N High Y N Hive Y N Kidn Y N Liver Y N Low Y N Low Y N Low Y N Mea	Are Immunization ttions: illin? • Yes • No nophilia atitis n Blood Pressure is rev Problems r Problems Blood Pressure JS	State Zip ns Current? Yes No Tetracycline? Yes No Y N Mitral Valve Prolapse Y N Mononucleosis Y N Rheumatic Fever Y N Scarlet Fever Y N Sickle Cell Anemia Y N Skin Rash Y N Tonsillitis	T I A

my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature

Date