CHITTENANGO
FAMILY DENTAL

WELCOME★

WE WOULD LIKE TO WELCOME YOUR CHILD TO OUR OFFICE!

TELL US ABOUT YOUR CHILD

Child's Name:_____ D.O.B:_____ Age:_____

Nickname:_____ **Male [ ] Female [ ]** Phone Number:_____

Address:_____

School:_____ Grade:_____ Hobbies:_____

GENERAL INFORMATION

Who is accompanying the child today? Name:_____ Relation:_____

Do you have legal custody of this child? **YES [ ] NO [ ]**

Whom may we thank for referring you ?_____Other siblings seen by us?_____

Previous Dentist?_____ Last visit date? _____

PARENT'S INFORMATION

Person responsible for account:_____ Parents marital status:_____

Primary Insurance through? Mother [ ] Father [ ] Guardian [ ] Step Parent [ ]

Name:_____ D.O.B:_____ Phone:_____

Address:_____ Social Security #._____

Employer:_____ Employers Phone #:_____

Primary Insurance Name:_____ Insurance Address:_____

ID#:_____ Group Number:_____ Insurance Phone #:_____

Secondary Insurance through? Mother [ ] Father [ ] Guardian [ ] Step Parent [ ]

Name:_____ D.O.B:_____ Phone:_____

Address:_____ Social Security #._____

Employer:_____ Employers Phone #:_____

Primary Insurance Name:_____ Insurance Address:_____

ID#:_____ Group Number:_____ Insurance Phone #:_____

I certify that my child is covered by insurance listed above, 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/Guardian: _____**Date:**_____

DENTAL HISTORY

Why did you bring the child to the dentist today? _____

Is the child currently in pain? YES [ ] NO [ ]

Does the child require antibiotics before dental treatment? YES [ ] NO [ ]

Has the child every had serious/difficult problems associated with previous dental work? YES [ ] NO [ ]

Is the child's water fluoridated? YES [ ] NO [ ] Is the child taking fluoridated supplements? YES [ ] NO [ ]

Has the child ever had and pain/tenderness in her/her jaw joint (TMJ/TMD)? YES [ ] NO [ ]

Does the child brush his/her teeth daily? YES [ ] NO [ ] Floss his/her teeth daily? YES [ ] NO [ ]

Child's Physician:_____ Phone Number:_____

Date of last Visit? _____ Is the child currently under the care of a physician? YES [ ] NO [ ]

PLEASE LIST ALL **PRESCRIPTIONS / OVER THE COUNTER DRUGS** THAT THE CHILD IS CURRENTLY TAKING?_____

ASIDE FROM ITEMS LISTED, PLEASE LIST ALL **DRUGS/THINGS THAT THE CHILD IS ALLERGIC TO**?:

_____

Latex? YES [ ] NO [ ] Metals/Nickel? YES [ ] NO [ ] Plastic? YES [ ] NO [ ]

MEDICAL HISTORY

Has the child experienced the following medical problems?

Abnormal Bleeding	YES	NO	Congenital Heart Defect	YES	NO	Hives	YES	NO
Hemophilia			Convulsions			Kidney Problems		
ADD/ADHD			Diabetes			Liver Problems		
AIDS/HIV			Epilepsy			Low Blood Pressure		
Anemia			Exposed to HIV,but neg.			Lupus		
Artificial Bones			Handicaps/Disabilities			Measles		
Artificial Joins/Valves			Hearing Impairment			Prosthetics		
Asthma			Heart Murmur			Rheumatic Fever		
Cancer			Hepatitis			Scarlet Fever		
Chicken Pox			High Blood Pressure			Tuberculosis		

Are your child's immunizations current? YES [ ] NO [ ]

Anything you would like to discuss with the doctor privately? YES [ ] NO [ ]

Please discuss any serious medical problems the child experiences/ed:_____

Does your child experience any of the following?	YES	NO		YES	NO
Breast Fed			Nursing Bottle Habits		
Chewing on Objects			Speech Problems		
Clenching/Grinding Teeth			Thumb/Finger Sucking		
Lip Sucking/Grinding			Tongue/Cheek Biting		
Mouth Breather			Tongue Thrust		
Nail Biting			Used Pacifier		

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changed in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent/Guardian:_____ **Date:**_____