

# Welcome

Welcome to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

You may fill this form out on-screen and print if desired

Today's Date: \_\_\_\_\_

How did you hear about us?  Google Ad  Yellow pages  Internet search  Word of mouth  Insurance company  
 Friend (who can we thank?) \_\_\_\_\_  Other: \_\_\_\_\_

## Your Child:

Child's Legal Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  Male  Female

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

### Mother

Stepmother  Guardian

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

DL#: \_\_\_\_\_

### Father

Stepfather  Guardian

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

DL#: \_\_\_\_\_

### Responsible Party

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

How would you like to be contacted?  
Please provide contact details next to  
your choice below:

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

Text: \_\_\_\_\_

## Parent's Marital Status

Single  Divorced  Married  Widowed  Separated

## Primary Dental Insurance

Insured's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Social Security #: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Insured address (if different from child): \_\_\_\_\_

Employer: \_\_\_\_\_ Date Employed: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ SSN / ID#: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

## Comments:

\_\_\_\_\_  
\_\_\_\_\_

*Pediatric Dentistry · Dr. Elaine Martinez*

# Health History

Has your child had difficulty with previous visits?

Yes  No If yes, explain \_\_\_\_\_

Please explain any medical problems that your child has:

Is your child receiving medication.  Yes  No If so, what?

Is your child allergic to any medication.  Yes  No

If so, what? \_\_\_\_\_

## Has your child ever had any of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Congenital Heart Defect |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Handicaps/Disabilities  |
| <input type="checkbox"/> Hepatitis                    | <input type="checkbox"/> Convulsions/Epilepsy    |
| <input type="checkbox"/> HIV/AIDS                     | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Hemophilia                   | <input type="checkbox"/> Abnormal Bleeding       |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Heart Murmur            |
| <input type="checkbox"/> Allergies                    | <input type="checkbox"/> Speech Impairments      |
| <input type="checkbox"/> Behavioral/Learning Problems | <input type="checkbox"/> Hearing Loss            |
| <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> Previous Surgery        |

## Child's Habits

How often does your child brush? \_\_\_\_\_

How often does your child floss? \_\_\_\_\_

How long since your last dental visit? \_\_\_\_\_

Were any x-rays taken at the last visit?  Yes  No

Previous Dentist: \_\_\_\_\_

Child's Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Is your child's water fluoridated? . . . . .  Yes  No

Does your child take fluoride supplements? . . . . .  Yes  No

## Does your child:

Eat between meals? . . . . .  Yes  No

Suck thumb/finger? . . . . .  Yes  No

Bite/Chew nails? . . . . .  Yes  No

Chew hard objects (pencils, etc.) . . . . .  Yes  No

Grind teeth? . . . . .  Yes  No

Clench jaws? . . . . .  Yes  No

## Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

## Health Update

Comments: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_