WELCOME

≈≈ TELL US ABOUT YOUR CHILD≈≈

Today's Date: _____ SS#: _____

CHILD'S NAME: _____
Last First Middle Name

Nickname: _____ Birthdate: _____/_____/_____ Age: _____ □Male □Female

Home Address: _____
City State Zip Code

Home #: (_____) _____ Parent's Cell #: (_____) _____

Parent's Email Address: _____

School: _____ Grade: _____

≈≈ WHO IS ACCOMPANYING THE CHILD TODAY?≈≈

Name: _____ Relation: _____

Do you have legal custody of this child? □YES □NO Is this child adopted? □YES □NO Is child in a foster home? □YES □NO

Whom may we Thank for referring you? _____Other family members seen by us: _____

Previous/Present Dentist: _____ Phone #: _____ Last Visit Date: _____

≈≈ PARENT'S INFORMATION≈≈

MOTHER: □Step Mother □Guardian SS #: _____

Name: _____ Birthdate: _____/_____/_____

Employer: _____ Work #: (____) _____

FATHER: □Step Father □Guardian SS #: _____

Name: _____ Birthdate: _____/_____/_____

Employer: _____ Work #: (____) _____

≈≈ PERSON RESPONSIBLE FOR ACCOUNT≈≈

NAME: _____ Relation: _____

Billing Address: _____ SS #: _____

Home #: (_____) _____ Work #: (_____) _____ Employer: _____

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name: _____ Home #: (____) _____ Cell #: (____) _____

Email:_____

≈≈ INSURANCE≈≈

PRIMARY INSURANCE Dental Coverage □YES □NO Orthodontic Coverage □YES □NO

Insurance Co. Name: _____

Subscriber Name:_____ Birthdate:_____ SS#:_____

SECONDARY INSURANCE Dental Coverage □YES □NO Orthodontic Coverage □YES □NO

Insurance Co. Name: _____

Subscriber Name:_____ Birthdate:_____ SS#:_____

≈≈ DENTAL HISTORY ≈≈

WHY DID YOU BRING THE CHILD TO THE DENTIST TODAY? ____

Has the child ever had a serious or difficult problem associated with previous dental work? ☐YES ☐NO

Is the child's water fluoridated? ☐YES ☐NO

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

Has the child ever had any pain or tenderness in his/her jaw joint (TMJ/TMD)? ☐YES ☐NO

Does your child have difficulty falling asleep? ☐YES ☐NO Staying asleep? ☐YES ☐NO Wake rested? ☐YES ☐NO

Anything you would like to discuss with the Doctor in private? ☐YES ☐NO

≈≈ MEDICAL HISTORY≈≈

PLEASE DESCRIBE THE CHILD'S CURRENT PHYSICAL HEALTH: ☐Good ☐Fair ☐Poor

Child's Physician: ______________________________________ Phone #: ______________________

Date of Last Visit: _______________ Is the child currently under the care of a physician? ☐YES ☐NO

Are the child's immunizations current? ☐YES ☐NO

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N	Abnormal bleeding	Y N	Congenital heart defect	Y N	HIV+/AIDS
Y N	ADD/ADHD	Y N	Convulsions	Y N	Kidney/Liver Problems
Y N	Anemia	Y N	Diabetes	Y N	Measles
Y N	Any hospital stays	Y N	Epilepsy	Y N	Mononucleosis
Y N	Any operations	Y N	Exposed to HIV- but Neg.	Y N	Rheumatic Fever
Y N	Artificial bones, joints, valves	Y N	Handicaps/Disabilities	Y N	Scarlet Fever
Y N	Asthma	Y N	Hearing impairment	Y N	Sickle Cell Dis./Traits
Y N	Bed wetting	Y N	Heart murmur	Y N	Skin Rash
Y N	Cancer	Y N	Hepatitis	Y N	Snoring
Y N	Chicken pox	Y N	Hives	Y N	Tuberculosis (TB)

Please list any serious medical conditions that the child has had: ______________________________

Please list all drugs that the child is currently taking: ______________________________

Please list all drugs or things that the child is allergic to: ______________________________

DOES OR DID THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

Y N	Lip Sucking/Biting	Y N	Nursing Bottle Habits	Y N	Was the child breast fed
Y N	Nail Biting	Y N	Thumb/Finger Sucking		

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CANCELLATION POLICY

I have been informed of St. Charles Family Dentistry Ltd's cancellation policy. I agree to pay a fee if I do not provide 24 hours notice or failure to attend appointment. (Initial) _________

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

____

Signature of parent or guardian *Date*

I affirm that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest 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 need.

____

Signature of parent or guardian *Date*

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FOR OFFICE USE ONLY

Reviewed medical/dental information with parent or guardian: ______________ Date:____________ Comments: