Welcome to ABC Dentistry for Children

CHILD'S INFORMATION

Today's Date _____

Child's Name: _____ Birthdate_____ Age_____ M____ F____

Child's Address _____

_____

City State Zip

Child's favorite activities _____

PARENT'S INFORMATION

Who brought the child today? _____ (Name) _____ (Relation)

FATHER'S NAME _____

Stepfather_____ Guardian_____

Does Father have legal custody of this child? Y / N

Address (if different) _____

_____

DOB _____ SS#_____

Hm# _____ Wk# _____

Cell# _____ DL# _____

Employer _____

Primary Email_____

MOTHER'S NAME _____

Stepmother_____ Guardian_____

Does Mother have legal custody of this child? Y / N

Address (if different) _____

_____

DOB _____ SS#_____

Hm# _____ Wk# _____

Cell# _____ DL# _____

Employer _____

Person financially responsible_____

INSURANCE INFORMATION

PRIMARY

Policyholder's Name _____

Ins. Co. Name _____

Ins. Address_____

_____

Ins. Phone _____

Group # _____

Relationship to Child_____

SECONDARY

Policyholder's Name _____

Ins. Co. Name _____

Ins. Address_____

_____

Ins. Phone _____

Group # _____

Relationship to Primary Holder_____

Relationship to Child_____

GENERAL INFORMATION

Whom may we Thank for referring you? _____

Relative or Friend not living with you:

Name_____ Phone: (____) _____

Address _____

_____

City State Zip

MEDICAL HISTORY

Please answer the following. Has your child ever had a history of...

Y N Abnormal Bleeding
Y N Hemophilia
Y N Any Operations
Y N Any Hospital Stays
Y N Chicken Pox
Y N Epilepsy / Seizures
Y N Kidney / Liver Problems
Y N Sickle Cell Disease / Traits
Y N ADD / ADHD
Y N Artificial Bones
Y N Hepatitis
Y N Measles
Y N Skin Rash
Y N Anemia
Y N Asthma
Y N Hearing Impairment
Y N Hives
Y N Tuberculosis (TB)
Y N Cerebral Palsy
Y N Cancer
Y N Diabetes
Y N Heart Murmur
Y N Heart Defect
Y N Heart Surgery
Y N HIV+ / AIDS
Y N Rheumatic / Scarlet Fever
Y N Autism
Y N RSV
At what age_____

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Child's Physician: _____

Phone #:_____ Date of Last Visit _____

	No	Yes
Are your child's Immunizations current?	☐	☐
Is the child currently under the care of a physician?	☐	☐
Has your child ever seen a cardiologist?	☐	☐
Is your child allergic to any drugs, latex, metals/nickel?	☐	☐

If yes, please list _____

Please list any medical problems that the child has had: _____

_____

Anything you would like to discuss with the Doctor in private? ☐ No ☐ Yes

Please list all medications your child is currently taking:

_____

DENTAL HISTORY

	No	Yes
Has the child ever had a serious / difficult problem associated with previous dental work?	☐	☐
Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)?	☐	☐
Does the child have any problem brushing?	☐	☐
Does your child have any problem flossing?	☐	☐

Does / did the child have any of the following habits?

N Y Lip Sucking / Biting
N Y Nail Biting
N Y Nursing or taking Bottle Habits
N Y Thumb / Finger Sucking

Why did you bring the child to the dentist today?

_____

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 to my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need to obtain a proper dental evaluation.

_____
Signature **Date**

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials:_____ Date: _____

Doctor's Comments:

_____

_____

_____

MEDICAL HISTORY UPDATE

1. Date:_____ **Signature:** _____
Comments: _____

2. Date:_____ **Signature:** _____
Comments: _____

3. Date:_____ **Signature:** _____
Comments: _____

4. Date:_____ **Signature:** _____
Comments: _____

5. Date:_____ **Signature:** _____
Comments: _____

6. Date:_____ **Signature:** _____
Comments: _____