



WELCOME



Tell us about your child

Today's Date: _____
 Child's Name: _____
 Birthdate: ____/____/____ Child's Age: _____
 Preferred Name: _____ Male Female
 Child's Home #: _____
 Child's Home Address: _____

Who is accompanying the child today?

Name: _____ Relation: _____
 Do you have legal custody of this child? Yes No
 Is the child adopted? Yes No
 Is the child in a foster home? Yes No
 Whom may we thank for referring you? _____

 Other siblings seen by us: _____
 Previous/Present Dentist: _____
 Last Visit Date: _____

Parental Information

Mother Step Mother Guardian
 Name: _____
 Birthdate: ____/____/____ Home # _____
 Work # _____ Cell # _____
 SS#: _____ Occupation: _____
 E-Mail: _____
 Parent's Marital Status: Single Married Divorced Widowed Partnered Separated

Father Step Father Guardian
 Name: _____
 Birthdate: ____/____/____ Home # _____
 Work # _____ Cell # _____
 SS#: _____ Occupation: _____
 E-Mail: _____

Primary Dental Insurance

Policy Owner's Name: _____
 Relationship to Patient: _____
 Policy Owner's Birthdate: ____/____/____
 Policy Owner's SS#: _____
 Insurance Co. Name: _____
 Insurance Policy ID #: _____
 Policy Owner's Employer: _____
 Insurance Co. Address: _____

 Insurance Co. Phone #: _____
 Insurance Co. Group #: _____

Secondary Dental Insurance

Policy Owner's Name: _____
 Relationship to Patient: _____
 Policy Owner's Birthdate: ____/____/____
 Policy Owner's SS#: _____
 Insurance Co. Name: _____
 Insurance Policy ID #: _____
 Policy Owner's Employer: _____
 Insurance Co. Address: _____

 Insurance Co. Phone #: _____
 Insurance Co. Group #: _____

I certify that my child is covered by the above Insurance Co. and I assign directly to Flanders Pediatric Dentistry 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 benefit. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

 Signature of parent or guardian

 Date

Why did you bring the child to the dentist today?

Has the child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Handicaps/Disabilities
Y	N	ADD / ADHD	Y	N	Hearing/Vision Loss
Y	N	Anemia	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Valves	Y	N	Hives
Y	N	Asthma	Y	N	HIV+ / AIDS
Y	N	Autism/Asperger's/PDD	Y	N	Kidney/Liver Problems
Y	N	Cancer	Y	N	Measles
Y	N	Chicken Pox	Y	N	Mononucleosis
Y	N	Congenital Heart Defect	Y	N	Rheumatic/Scarlet Fever
Y	N	Convulsions	Y	N	Sensory Issues
Y	N	Diabetes	Y	N	Sickle Cell Disease/Traits
Y	N	Epilepsy	Y	N	Skin Rash
Y	N	Exposed to HIV, but Neg.	Y	N	Tuberculosis (TB)

Has your child ever had a serious / difficult problem associated with previous dental work?

If yes, please explain:

Is the child's water fluoridated?

Is the child taking fluoridated supplements?

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)?

Does the child brush his / her teeth daily?

Floss his / her teeth daily?

Has the child ever taken Fosamax, Actonel, Boniva or any other bisphosphonate?

Child's Physician: _____

Phone # _____

Date of last visit: _____

Please describe the child's current physical health:

Good Fair Poor

Please list all medications the child is currently taking:

Aside from items listed below, list all medications/things the child is allergic to:

Latex Y N Metals/Nickel Y N Plastic Y N

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

Y N Lip Sucking / Biting Y N Nursing Bottle Habits

Y N Nail Biting Y N Thumb/Finger Sucking

Was the child breast fed? Y N

I understand that the information that I have given is correct to the best of my knowledge, that it 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Individual refused to sign

Signature of parent or guardian

Date

Signature of parent or guardian

Date