Child's Name_____Nickname_____Gender: _____Birth Date____

Reason for this visit_____

Is this your child's first dental visit? ___ Date of last visit: _____Previous Dentist_____

Your child's attitude toward previous dental care?_____

How may we make your child's experience positive and comfortable?_____

Have we seen other children in your family? _____ Name_____

How did you hear about our office?_____

Parent/Guardian(Primary):

First Name_____ Last Name_____Middle Initial_____

Address_____ City, State, Zip _____

Home Phone_____ Cell_____ Email_____

Relationship to Patient_____

Parent/Guardian(Secondary):

First Name_____ Last Name_____Middle Initial_____

Address_____ City, State, Zip _____

Home Phone_____ Cell_____ Email_____

Relationship to Patient_____

Emergency Contact:

First Name_____ Last Name_____Middle Initial_____

Address_____ City, State, Zip _____

Home Phone_____ Cell_____ Email_____

Relationship to Patient_____

Primary Dental Insurance:

Policy Owners Name:_____ Relationship to Patient_____

Policy Owners D.O.B._____ Social Security Number_____-_____-_____

Policy Owners Employer_____ Employers Address_____

Plan,Local, or Group#_____ Policy I.D. #_____

Is there Secondary Insurance?(Please Circle) YES NO

Primary Physician

Dr.'s Name_____ Address_____ Phone_____

Is Your child taking any medication_____ If Yes, Please list_____
Reason_____
Has your child ever been hospitalized?___ When?_____ Reason_____
Are Your child's Immunizations current?_____
Allergies to Medications or Food:_____

Is your child allergic or sensitive to latex_____

Dental Information

Was your child bottle fed?____ Until what Age?_____ Or breast fed?_____ Until what age?_____
Does your child have any mouth habits, such as finger/thumb sucking_____ Pacifier_____
Other_____
Has your child had any injuries to their teeth, mouth, or head?_____ When?_____
Details_____
Does your child floss?_____ Does an adult assist with flossing?_____
Has either parent or child been treated orthodontically?____
Name of Orthodontist_____

How would you expect your child to behave in our office?(Please Circle)

Shy Stubborn Anxious Frightened Age Appropriate

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to determine appropriate and healthful dental treatment. If there is any change in my child's medical status I will inform the dentist.

I authorize the dental insurance company provided to this office, to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize this signature on all insurance submissions

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

PATIENT/GUARDIAN NAME **SIGNATURE** **DATE**