WELCOME

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Pediatric Dentistry
Diplomate, American Board of Pediatric Dentistry

Tell Us About Your Child

Date ..... Birthdate ..... Child's Age .....

Child's Name ..... Sex ☐ M ☐ F
Last Name First Name Middle Initial

Nickname ..... Hobbies .....

Home Address .....
Street City State Zip

School Name ..... School Phone ( ) .....

Person financially responsible ..... Home Phone ( ) ..... Work Phone ( ) .....

What is the primary reason for today's visit? ..... Is your child adopted? ☐ Yes ☐ No

Has any member of your family been or is currently a patient in our office? ☐ Yes ☐ No If yes, name .....

Whom may we thank for referring you? .....

Parent's Information

Father's / Guardian's Name .....

Address (If different from patient's) .....

Home Phone ( ) ..... Work Phone ( ) .....

Cell Phone ( ) .....

E-mail .....

Employer .....

Soc.Sec. # ..... Birthdate .....

Mother's / Guardian's Name .....

Address (If different from patient's) .....

Home Phone ( ) ..... Work Phone ( ) .....

Cell Phone ( ) .....

E-mail .....

Employer .....

Soc.Sec. # ..... Birthdate .....

Parents are: ☐ Married ☐ Separated ☐ Divorced Name of parent who resides with the child: .....

Nearest relative: ..... Address ..... Phone ( ) .....

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ..... Phone .....

Address .....

Group # ..... Policy # .....

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ..... Phone .....

Address .....

Group # ..... Policy # .....

Dental History

Date of last visit to a dentist ..... For what service? .....

	YES	NO		YES	NO
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits - thumb/finger sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ ☐

Please Complete Both Sides