We would like to welcome you and your child to Fine Dentistry. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that last a lifetime.

Tell Us About Your Child

Today's Date : _____

Child's Name : _____
LAST FIRST MI

Nickname : _____ ☐ Male ☐ Female

Child's Birthdate : _____ Child's Age: _____

School : _____ Grade: _____

Child's Home # : _____

Child's Home Address:

_____ _____ _____
Apt #

_____ _____ _____
City State Zip

Parent's Email _____@_____

Person Responsible for Account

Name: _____ Relation: _____

Billing address: _____

_____

Wk# _____ Hm# _____ Cell# _____

Employer _____

SS# _____ DL# _____

Person Responsible for making appointment?

Name : _____

Wk# _____ Hm# _____ Cell# _____

Who is accompanying the child today

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ YES ☐ NO

Who may we Thank for referring you? _____

Other family members seen by us: _____

_____

Previous/Present Dentist: _____

Last visit date: _____

Parent's marital status :

☐ SINGLE ☐ MARRIED ☐ SEPARATED

☐ WIDOWED ☐ DIVORCED

Primary Dental Insurance

Ins. Co. Name : _____

Ins. Co. Address: _____

Ins. Co. Phone : _____

Policy # _____ Group# _____

Insured's Name: _____

Relationship to patient: _____

Insured's Birthday: __/__/__ SS#: _____

Insured's Employer: _____

Insured's email address : _____

Mother's Information

Name: _____

Status: ☐ Birth Mother ☐ Step Mother ☐ Guardian

Hm# _____ Wk# _____ Cell # _____

Employer: _____

SS# : _____

Father's Information

Name: _____

Status: ☐ Birth Father ☐ Step Father ☐ Guardian

Hm# _____ Wk# _____ Cell # _____

Employer: _____

SS# : _____

Secondary Dental Insurance

Ins. Co. Name : _____

Ins. Co. Address: _____

Ins. Co. Phone : _____

Policy # _____ Group# _____

Insured's Name: _____

Relationship to patient: _____

Insured's Birthday: __/__/__ SS#: _____

Insured's Employer: _____

Insured's email address _____

Dental History

- Has your child ever had difficult problem associated with previous dental work? YES NO
- Does your child brush daily? YES NO
- Does your child floss daily? YES NO
- Does your child take fluoridated supplement? YES NO
- Does your child have these habits?
  - Thumb/Finger Sucking YES NO
  - Lip Sucking/Biting YES NO
  - Nail Biting YES NO
  - Nursing Bottle habits YES NO
  - Teeth grinding YES NO

Medical History

- Any stays in hospital in the past YES NO
  Reason?: _____
- Is the child currently under the care of a physician? YES NO
- Child's Physician: _____
- Phone #: _____
- Please describe your child's current physical health:

_____

_____

_____

Medication History

- Please list all drugs the your child currently taking:

_____

_____

- Please list all drugs that your child is allergic to:

_____

_____

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

Y	N	Heart Murmur	Y	N	Congenital Heart Defect
Y	N	Cancer	Y	N	Convulsion/Epilepsy
Y	N	Diabetes	Y	N	Abnormal bleeding
Y	N	Rheumatic fever	Y	N	Hearing Impairment
Y	N	HIV+/AIDS	Y	N	Any Operation
Y	N	Hemophilia	Y	N	Tuberculosis (TB)
Y	N	Asthma	Y	N	Kidney/Liver Problems
Y	N	Hepatitis	Y	N	Handicaps/Disabilities

- **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 of confidence, and it is my responsibility to inform this office of any changes in my child's medical status**
- **I also authorize the dental staff to perform the necessary dental services my child may need.**

_____ _____

Signature of parent or guardian Date

Fine Dentistry is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

FOR OFFICE USE ONLY, DO NOT FILL IN THIS BOX

Medical History Review and Update

1. Date _____ Comments _____ Signature _____
2. Date _____ Comments _____ Signature _____
3. Date _____ Comments _____ Signature _____