



If you have Dental Insurance Coverage for the Child, please fill out below:

Name of Subscriber \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance Phone #: \_(\_\_\_\_)\_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

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Insurance Phone #: \_(\_\_\_\_)\_\_\_\_\_

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**Release**

I certify that my child is covered by \_\_\_\_\_ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

**Dental History**

Why did you bring the child to the dentist today? \_\_\_\_\_

Is the child currently in pain? Yes / No

Does the child have a medical condition that requires antibiotic treatment? Yes / No

Has the child ever had a serious / difficult problem associated with previous dental work? Yes / No

Is the child's water fluoridated? Yes / No

Is the child taking fluoridated supplements? Yes / No

Has the child ever had any pain/ tenderness in his/her jaw joint (TMJ/ TMD)? Yes / No

Does the child brush his/her teeth daily? Yes / No

Floss his/her teeth daily? Yes / No

Child's Physician: \_\_\_\_\_

Phone #: \_(\_\_\_\_)\_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Is the child currently under the care of a physician? Yes / No

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

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking:  
\_\_\_\_\_  
\_\_\_\_\_

Aside from the items below, please list all drugs/ things that the child is allergic to:  
\_\_\_\_\_  
\_\_\_\_\_

Yes / No Latex      Yes / No Metals/ Nickel      Yes / No Plastic

**Medical History**

**Has the child experienced the following medical problems?**

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Heart Murmur
Y	N	ADD / ADHD	Y	N	Hepatitis
Y	N	AIDS / HIV+	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	Hives
Y	N	Any Hospital Stays / Operations?	Y	N	Kidney Problems
Y	N	Artificial Bones / Joints / Valves	Y	N	Liver Problems
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Cancer	Y	N	Lupus
Y	N	Chicken Pox	Y	N	Measles
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Convulsions	Y	N	Mononucleosis
Y	N	Diabetes	Y	N	Prosthetics
Y	N	Epilepsy	Y	N	Rheumatic Fever
Y	N	Exposed to HIV, but Neg.	Y	N	Scarlet Fever
Y	N	Genetic Disorder	Y	N	Skin Rash
Y	N	Handicaps / Disabilities	Y	N	Tuberculosis (TB)
Y	N	Hearing Impairment			

Are the child's immunizations current? Yes / No  
Anything you would like to discuss with the Doctor in private? Yes / No

Please discuss any serious medical problems the child experiences / ed:

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Does the child experience any of the following?

Y	N	Breast Fed	Y	N	Speech Problems
Y	N	Clenching / Grinding	Y	N	Thumb / Finger Sucking
Y	N	Lip Sucking/ Biting	Y	N	Tongue / Cheek Biting
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Pacifier
Y	N	Nursing Bottle Habits			

Our office committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. 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.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date