



Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.



Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex M F Age _____
 Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____
 Street City State Zip

Mailing Address _____
 Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

Father's/Guardian's Name _____ Address (if different from patient's) _____ _____ Home Phone (____) _____ Work Phone (____) _____ (if different from above) (if different from above) E-mail _____ Employer _____ Soc. Sec. # _____ Birthdate _____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone (____) _____ Address _____ Group # _____ Policy # _____	Mother's/Guardian's Name _____ Address (if different from patient's) _____ _____ Home Phone (____) _____ Work Phone (____) _____ (if different from above) (if different from above) E-mail _____ Employer _____ Soc. Sec. # _____ Birthdate _____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone (____) _____ Address _____ Group # _____ Policy # _____
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Is your child eligible for treatment under Medical Assistance? Yes No Child's Medical Assistance I.D. # _____

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

Has child complained about dental problems? <input type="checkbox"/> YES <input type="checkbox"/> NO Does child brush teeth daily? <input type="checkbox"/> YES <input type="checkbox"/> NO Does child use floss every day? <input type="checkbox"/> YES <input type="checkbox"/> NO Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is fluoride taken in any form? <input type="checkbox"/> YES <input type="checkbox"/> NO Any injuries to mouth, teeth, head? <input type="checkbox"/> YES <input type="checkbox"/> NO Any unhappy dental experiences? <input type="checkbox"/> YES <input type="checkbox"/> NO
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