Updated 11/19/09

Welcome to Wennersten Dental Care!
Please fill out this form; the better we communicate, the better we can care for your child.

About Your Child

Name: _____
Last

_____
First Middle Initial

☐ Male
☐ Female

Nickname:_____

Birth date:_____/_____ /_____

School: _____

Address: _____
Street

_____
City State ZIP

Home Phone: (_____) _____

Other family seen by us: _____

Previous Dentist: _____

Last Visit Date:_____

Parent (Guardian) Information

Who is accompanying the child today (name & relationship)?

_____

If it were an option, would you prefer to receive appointment reminders by email? …….…….. Yes ☐ No ☐

Mother

Name: _____

Birth date:_____/_____/_____SS#: _____

Home: (_____) _____Cell: (_____) _____

Work: (____) _____ Email:_____

Father

Name: _____

Birth date:_____/_____/_____SS#: _____

Home: (_____) _____Cell: (_____) _____

Work: (____) _____ Email:_____

Person Responsible for Account

Who is responsible for the child's account?

_____

Who is responsible for making the child's appointments?

_____

Dental Information

Reason for today's visit_____

_____

Please explain briefly if you have questions or concerns about your child's dental conditions (e.g. orthodontic treatments)

_____

_____

Is the child currently in pain? ..…… ☐ Yes ☐ No

Has the child ever had a serious problem associated with any previous dental work? ……..… ☐ Yes ☐ No

Has the child experienced any of the following in his/her jaw joints?

Clicking …… ☐ Yes ☐ No
Pain (jaw joint, ear, neck) …… ☐ Yes ☐ No
Difficulty in opening or closing ……. ☐ Yes ☐ No
Difficulty chewing ……... ☐ Yes ☐ No

Does the child clench or grind his/her teeth? ….. ☐ Yes ☐ No

Has the child had any orthodontic treatment? …. ☐ Yes ☐ No

What kind of water does the child usually drink?
☐ City Water ☐ Well Water ☐ Bottled Water ☐ Other

Does the child take fluoridated supplements? … ☐ Yes ☐ No

Do the child's gums bleed in brushing/flossing? ☐ Yes ☐ No

Does the child brush his or her own teeth? ….. ☐ Yes ☐ No

How many times a **week** does the child floss? _____/ week

How many times a **day** does the child brush? _____/day

Please let us know if there is someone we can thank for referring you.

_____

Continued on back…

Health Information

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

Does the child need to take antibiotics before dental appointments? …….…….. ☐ Yes ☐ No

Is the child currently undergoing any treatment? ☐ Yes ☐ No

If so, please explain: _____

_____

Please list any prescription medications your child is taking:

_____

_____

Be sure to list any blood thinners (i.e. Coumadin, Warfarin) and biphosphonates (i.e. Fosamax, Actonel, Boniva) for osteoporosis.

Medical History

Please mark if your child has ever had any of the following:

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Artificial Joints/ Valves
- ☐ Asthma
- ☐ Autism
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Chicken Pox
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Hay Fever
- ☐ Hearing Impairments
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hives
- ☐ HIV+/AIDS
- ☐ Hospitalized for Any Reason
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Measles
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Rheumatic/Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ Transplant
- ☐ Tuberculosis (TB)

☐ **None of the above applies**

Are your child's immunizations current? ……. ☐ Yes ☐ No

Does/did your child have any of the following habits?

- Lip Sucking/Biting …… ☐ Yes ☐ No
- Nail Biting …….. ☐ Yes ☐ No
- Nursing Bottle Habits …….. ☐ Yes ☐ No
- Thumb/Finger Sucking ……... ☐ Yes ☐ No

Was the child breast-fed? ……. ☐ Yes ☐ No

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa

☐ **None of the above applies**

Please list any other drugs your child is allergic to:

_____

_____

Dental Insurance----Please fill completely

☐ **I do not have dental insurance**

Primary Dental Insurance

Insurance Co. Name: _____

Group Number: _____

Subscriber's Name: _____

Subscriber's Birth Date: _____/_____/_____

Subscriber's SS#: _____

ID# (if different from SS#) _____

Subscriber's Employer _____

Relationship to Patient: _____

☐ **I do not have secondary dental insurance**

Secondary Dental Insurance

Insurance Co. Name: _____

Group Number: _____

Subscriber's Name: _____

Subscriber's Birth Date: _____/_____/_____

Subscriber's SS#: _____

ID# (if different from SS#) _____

Subscriber's Employer _____

Relationship to Patient: _____

Payment is due in full at the time of treatment unless prior arrangements have been made. Insurance co-pays are due within 30 days of the billing date. Since we set aside time specifically for you, please note that there may be a fee for breaking an appointment without contacting us or cancelling without providing us at least 48 business hours' notice.

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

I authorize my insurance company to pay Wennersten Dental Care the benefits otherwise payable to me.

I understand that I am responsible for payment of services rendered and also responsible for paying any portion of my treatment fees that my insurance does not cover. I also understand that any fees for overdue payments, broken appointments, and cancellation with less than 48-business-hour notice will be my responsibility.

X_____ ___/___/____

Signature of a parent or guardian **Date**