About Your Child

Name: ____
Last

____
First Middle Initial

☐ Female
Nickname:_____________________________ ☐ Male ☐ Other

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? ………………… Phone ☐ Email ☐ Text ☐

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.

____

Medical History

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 bisphosphonates (i.e. Fosamax, Actonel, Boniva) for osteoporosis.

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

- ☐ Abnormal Bleeding
- ☐ ADD/AHD
- ☐ 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 Problem
- ☐ Liver Disease
- ☐ Measles
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Rheumatic/Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Skin Rash
- ☐ Tuberculosis (TB)

☐ None of the above applies

List any other serious medical conditions you have had:

____

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 ☐

Please check if your child is allergic any of the following:

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry / Metals
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other

☐ None of the above applies

Please list any other drugs that you are 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 (if applicable)

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 24 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 24 business hour notice will be my responsibility.

X________________________________ ____/_____/____