Welcome to our office! Our goal is to make your visit enjoyable and educational.
We want your child to have a healthy & beautiful smile that will last a lifetime!

About your Child:

Legal Name: ____ Nickname: ______________

Birth date: ______/______/______ Gender: M F __________________
mo. day yr.

Home Address: ____ Zip: _____________

General Dentist? __________________________ School Name: __________________________

Has your child ever been to an orthodontist? Yes No

Who is accompanying the child today? ____

Who may we thank for referring you? ____

Mother's Information: ____Mother ____Grandmother ____Guardian

Name: ____________________________________ Married? Y N Spouse: ________________

Home Address: ____ Zip: _____________

Cell #: _____-_______-_________ Alternate: Cell / Home / Work / Spouse _____-_______-__________

❑ Check this box to opt OUT of text appointment reminders ↑circle one↑

Email: ____

Father's Information: ____Father ____Grandfather ____Guardian

Name: ____________________________________ Married? Y N Spouse: ________________

Home Address: ____ Zip: _____________

Cell #: _____-_______-_________ Alternate: Cell / Home / Work / Spouse _____-_______-__________

❑ Check this box to opt OUT of text appointment reminders ↑circle one↑

Email: ____

Person Responsible for the Account: *please fill out all info below or note who if already listed above.

Name: ______________________________________ Relationship to Patient: _______________

Billing Address: ____ Zip: _______________

Cell #: _____-_______-_________ Alternate: Cell / Home / Work / Spouse _____-_______-__________

Email: ____

Do you have dental insurance? Yes / No If yes, please fill out our insurance form.

Your Child's Dental & Medical History

Patient Name: ____

Has your child ever had any pain or tenderness in their jaw joint (TMJ/TMD)? Yes No

Does your child brush their teeth daily? Yes No

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

Pediatrician/Physician: _________________________________ Phone #: _______________

Have your child ever had any of the following medical problems?

Heart Murmur	Y / N	Convulsions/Epilepsy	Y / N
Cancer	Y / N	Abnormal Bleeding	Y / N
Diabetes	Y / N	Hearing Impairment	Y / N
Rheumatic Fever	Y / N	HIV+/AIDS	Y / N
Asthma	Y / N	Hemophilia	Y / N
Hepatitis	Y / N	Kidney/Liver Problems	Y / N
Tuberculosis (TB)	Y / N	Allergies to any Drugs	Y / N
Any Operations	Y / N	Any Hospital Stays	Y / N
Congenital Heart Defect	Y / N	**Allergic to LATEX**	Y / N

Please explain any notable medical problems and/or allergies your child has or had:__________

____

Do you require antibiotic coverage prior to your dental appointments? Yes / No

Please list any medication that your child is presently taking:__________________________

____

Does your child have any of the following conditions or habits:

Snoring/Apnea	Y / N	Thumb/Finger Sucking	Y / N
Nail Biting	Y / N	Lip Sucking/Biting	Y / N

I understand that the information that I have given today is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my child's medical status.

Signature:____Date:____________