WELCOME

We are pleased to welcome you and your child to our practice. Please fill out this form as completely as you can. We look forward to working with you in maintaining your child's dental health.

ABOUT YOUR CHILD

Child's Name:_____
Nickname:_____
Birthdate: _____ Age:_____ Sex:_____
Hobbies: _____
School: _____
Reason for visit: _____
_____
Referred to us by: (we wish to thank them)
_____

DENTAL HISTORY

	Yes	No
Is this your child's first dental visit?	☐	☐
Previous dentist:_____	☐	☐
City:_____ Last visit:_____		
Has your child had an unfavorable experience in a previous dental (or medical) office?	☐	☐
Are you aware of any current dental problems, which you expect will require treatment?	☐	☐

Has your child had any history of:

☐ cavities ☐ toothaches ☐ pain
☐ broken teeth ☐ extracted teeth
☐ gum infection ☐ missing permanent teeth
☐ extra permanent teeth

Has your child experienced injuries to the mouth, teeth or jaws (falls, blows, chips, etc.)?	☐	☐
Did nursing, bottle feeding or bottle habits continue beyond 12 months of age?	☐	☐
Does (or did) your child have any oral habits beyond one year of age?	☐	☐

☐ Thumb ☐ Finger(s) ☐ Blanket
☐ Pacifier ☐ Grinding
☐ Still present ☐ Discontinued at age _____

Do you think your child will cooperate for dental treatment?	☐	☐

PREVENTIVE DENTAL HISTORY

	Yes	No
How often does your child brush? _____		
Is tooth brushing supervised?	☐	☐
By whom?_____		
Is dental floss used?	☐	☐

Does your child receive:

☐ Fluoride in vitamins ☐ Bottled water
☐ Fluoride tablets/drops ☐ Well water
☐ Fluoridated water

MEDICAL HISTORY

Child's physician:_____
City:_____
Phone #:_____
Last physician's visit: _____
Seen for:_____

	Yes	No
Is your child in good health right now?	☐	☐
Is your child presently under care for any medical problems or condition? If so, what?_____	☐	☐
Is your child currently taking any drugs or medication? If so, what?_____ Dose:_____	☐	☐
Has your child a history of any of the following?		
Congenital heart diseases, heart murmor or heart damage from rheumatic fever	☐	☐
Blood disorders, bleeding problems, anemia, or sickle cell disease	☐	☐
Seizures disorder, epilepsy, convulsions, cerebral palsy, or brain injury	☐	☐
Asthma, pneumonia, tuberculosis, cystic fibrosis or breathing difficulties	☐	☐
Sight or hearing disorders or limitations	☐	☐
Stomach, intestinal, kidney, or liver problems, including jaundice or hepatitis	☐	☐
Diabetes, thyroid disorders or other glandular problems	☐	☐
Immune syustem disorders, including arthritis, or muscle problems or weaknesses	☐	☐
Cancer, tumors or growths	☐	☐
Joint or limb problems, including arthritis, or muscle problems or weaknesses	☐	☐
Allergies to any food, drugs or medications or to latex, rubber	☐	☐
Has the child ever been hospitalized / had surgery? If so, for what?_____	☐	☐
Are there other medical problems or conditions you feel should be brought to the doctor's attention? If so, what?_____	☐	☐

_____

SOCIAL AND DEVELOPMENTAL HISTORY

	Yes	No
Was your child premature or low birthweight?	☐	☐
Does your child have any learning disabilities, developmental delay or intellectual impairment?	☐	☐
Does your child have any behavioral problems, attention disorders or communication problems?	☐	☐
Has your child received behavioral, psychological, or psychiatric evaluation, counseling or treatment?	☐	☐

How would you expect your child to behave in our office?_____

How would you describe your child as?

☐ Shy ☐ Frightened ☐ Anxious ☐ Outgoing

RESPONSIBLE PARTY

Father:_____ Birthdate:_____

Address:_____

City/Sate/Zip:_____

SS#:_____Drivers License#:_____

Home Phone #:_____

Work Phone #: _____

Cell Phone #: _____

E-mail Address:_____

Employer:_____

Occupation: _____

Mother:_____ Birthdate: _____

Address:_____

City/Sate/Zip:_____

SS#:_____Drivers License#:_____

Home Phone #:_____

Work Phone #: _____

Cell Phone #: _____

E-mail Address:_____

Employer:_____

Occupation: _____

INSURANCE

Primary Insurance: _____

Group #: _____

Policy Holder Name: _____

Membership #:_____

Secondary Insurance:_____

Group #: _____

Policy Holder Name: _____

Membership #:_____

NEAREST RELATIVE/FRIEND

Name:_____ Relationship:_____

Phone #: _____

Name:_____ Relationship:_____

Phone #: _____

CREDIT REFERENCE

Name of Company: _____

Account #:_____ Branch/Phone:_____

Name of Company: _____

Account #:_____ Branch/Phone:_____

AUTHORIZATION

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.** If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for the collection fees, attorney fees, and applicable court cost, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to Dr. Maria Aganon-Fu. I authorize the release of my dental information necessary to process this claim and all future claims.

I give the doctors permission to use such measure as deemed necessary in their professional judgment to render a diagnosis and perform the necessary dental services for my minor/child.

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictness of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

Signature: _____

Relationship to child:_____ Date:_____