Welcome!

Thank you for giving us the privilege of seeing your child. We are axious to provide the best possible care. The answers to these questions will help make this possible.

Date:____________

Your Child

Child's First Name____________ Last____________ Nickname____________ Sex ____

SS#:____________ Birthdate____________ Age____

Child's Home Address____________ City____________ State____ Zip____

School____________ Grade____ Favorite Subject____________

Favorite TV Show____________ Favorite Game or Hobbies____________

Favorite Sport____________ Favorite Pet____________ Favorite Person____________

Brothers and Sisters (if any) and ages____________

Father or ___Stepfather ___Guardian

Name____________

Home Phone____________ Cell____________

Work Phone____________ Ext.____

E-mail____________

Employer____________

Occupation____________

SS#____________ D.O. B.____________

DL#____________

Marital Status ___Single ___Married ___Divorced ___Widowed ___Separated

Mother or ___Stepmother ___Guardian

Name____________

Home Phone____________ Cell____________

Work Phone____________ Ext.____

E-mail____________

Employer____________

Occupation____________

SS#____________ D.O.B.____________

DL#____________

Marital Status ___ Single ___ Married ___Divorced ___Widowed ___Separated

Who is responsible for making appointments? ___Mother, ___ Father, or:

Name____________ Relationship____________

Home Phone____________ Cell____________ Work Phone____________ Ext____

E-Mail____________

Best Method to Contact:____________ **Best time to Contact:**____________

Responsible Party: ___Both Parents, ___Mother, ____Father, or:

Name____________ Relationship____________

Address____________ City____________ State____ ZIP____

E-Mail____________ SS#____________

Home Phone #____________ Cell#____________ Driver's License #____________

Primary Insurance

Insured's Name ____________

Relationship ____________

Birthdate ____________ SS#____________

Employer____________

Insurance Company ____________

Group # ____________ Employee # ____________

Ins. Co. Address ____________

City____________ State____ Zip ____

Additional Insurance

Insured's Name ____________

Relationship ____________

Birthdate____________ SS#____________

Employer____________

Insurance Company ____________

Group # ____________ Employee # ____________

Ins. Co. Address ____________

City ____________ State____ Zip____

Dental History

Is this the child's first visit to a dentist? ____ Yes ____ No Date of Last Visit to a dentist: ____

Name of Previous Dentist: ____ May we request records? ____ Yes ____ No

Explain any unpleasant dental experiences your child had: ____

Any tooth/mouth injuries?: ____ Any Discomfort?: ____

Circle any of the following habits your child HAD: thumbsucking; finger-sucking; pacifier; grinding; tongue-thrusting

Circle any of the following habits your child HAS: thumbsucking; finger-sucking; pacifier; grinding; tongue-thrusting

My child ____did not, ____ did, or ____does fall asleep with a baby bottle. Contents of bottle: ____

Does your child have speech issues? ____Yes ____No Explain: ____

What is your child's attitude towards dentistry? ____ Do you anticipate difficulty in treatment? ____

Oral Hygiene

How often does your child brush? ____ How often does your child floss? ____

Does anyone in the family ever help your child with brushing and flossing? ____ Yes ____ No

Is your house water fluoridated? ____Yes ____No Any other sources of fluoride? ____

Any abnormal dietary habits? ____

Health History

Child's Physician: ____ Phone #: ____

Date of last examination: ____ Results: ____

Yes No Child under care of physician now? Why? ____

Yes No Child receiving any medication now? What? ____

Yes No Child ever been hospitalized? Why? ____

Yes No Child bleeds excessively when cut? Describe: ____

Yes No Child has good physical coordination? Explain: ____

Yes No Child has emotional or nervous problems? Explain: ____

Does your child have any allergies to the following? (circle allergies):

penicillin; other antibiotics; novacaine (local anesthetics); aspirin; latex; any foods; other (explain below)

____

Does your child have or ever had any of the following? (place an "X" and explain below):

____ Anemia	____ Cleft Lip	____ Hearing Problems	____ Liver Problems	____ HIV/AIDS
____ Asthma	____ Cleft Palate	____ Heart Problems	____ Rheumatic Fever	____ Hemophilia
____ Autistic Spectrum	____ Convulsions	____ Jaundice	____ Sight Problems	____ Acid Reflux
____ Bladder Problems	____ Diabetes	____ Kidney Problems	____ Thyroid Problems	____ Disabilities
____ Cerebral Palsy	____ Epilepsy	____ Mentally challenged	____ Tuberculosis	____ Chronic Cough
____ Chronic Sinus	____ Fainting	____ Heart Murmurs	____ Cancer	____ Other

____

Would you like to talk with the doctor privately about certain, personal issues? ____ Yes ____ No

Conclusion and Thank You!

Whom may we thank for referring your child to us? ____

If not referred, how did you hear of us? ____

We strive to make each of your child's visits pleasant and comfortable. Thank you for this opportunity!

Patricia Templeton, D.D.S., Richard L. Sherman, D.D.S.

Authorization and Release

If this patient is a minor, it becomes necessary that signed permission be obtained from the parent or guardian. Authorization is hereby granted. I understand that providing incorrect information can be dangerous and it is my responsibility to inform the office of any changes in my child's health. I also authorize the staff to perform the necessary services that my child needs only after a consultation and/ or explanation. Furthermore, I will be responsible for any bill incured on this patient for dental treatment or, if I indicated someone else is responsible, permission is granted for verification.

Signature: ____

Relationship to child: ____