WELCOME KIDS!

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!
www.AscensionSmiles.com

Tell Us About Your Child

Today's Date: ______________________________
Child's Name: ______________________________
Last *First* *Middle*
Birthdate: ____ / ____ / ____ Child's Age: __________
Nickname: __________________ ☐ Male ☐ Female
School: ____________________ Grade:__________
Siblings: ______________________________
Home Phone: ( ) ______________________________
Social Security #: ______________________________
Home Address: ______________________________
Apt. #
____
City *State* *Zip Code*

General Information

Who is accompanying the child today? ______________
Name: ________________ Relation: ______________
Do you have legal custody of the child? ☐ Yes ☐ No
Who may we thank for referring you? ______________
Previous Dentist: ______________ Last visit: ________

Emergency Contact:
Name: ______________ Phone #: ( ) ____________
Address: ______________________________
____
City *State* *Zip Code*
Primary Language Spoken: ______________________

Parent's Information

Person responsible for account: ______________________
Mother's Name: ______________ DOB: ______________
☐ Mother/Father ☐ Step-Mother/Father ☐ Guardian
Address: (if different from Child's): ______________
____
SS #: ______________________________
Work #: ( ) ____________ Cell #: ( ) ____________
Email Address: ______________________________
Employer: ______________________________
Employer's Address: ______________________________
____
City *State* *Zip Code*
If you have Dental Insurance for your Child, please fill out below:
Insurance Co. Name: ______________________________
ID #: ______________ Group #: ______________

Parent's Marital Status: ______________________
Father's Name: ______________ DOB: ______________
☐ Mother/Father ☐ Step-Mother/Father ☐ Guardian
Address: ______________________________
____
SS #: ______________________________
Work #: ( ) ____________ Cell #: ( ) ____________
Email Address: ______________________________
Employer: ______________________________
Employer's Address: ______________________________
____
City *State* *Zip Code*
If you have Dental Insurance for your Child, please fill out below:
Insurance Co. Name: ______________________________
ID #: ______________ Group #: ______________

Release

I certify that my child is covered by ______________________ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance company does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

______________________________ ______________
Signature of Parent/Guardian *Date*

Dental History

Why did you bring the child to see the dentist today? ____________________

____

Has the child ever taken any diet pills such as Phen-Fen? ❑ Yes ❑ No
(Also known as Redux or Pondimin) If so, when? ____________

Is the child currently in pain? ❑ Yes ❑ No

Does the child require antibiotics before dental treatment? ❑ Yes ❑ No

Has the child ever had a serious/difficult problem associated with previous dental work? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No

Is the child taking fluoridated supplements? ❑ Yes ❑ No

Has the child ever had any pain/tenderness in in his/her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Does the child brush his/her teeth daily? ❑ Yes ❑ No

Does the child floss his/her teeth daily? ❑ Yes ❑ No

Child's Physician: ____________________

Phone #: (   ) ____________ Date of Last Visit: ____________

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

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list any drugs that the child is currently taking: ____________

____

Please list all drugs that the child is allergic to:

____

Y N Allergic to Latex

Y N Allergic to Metals

Y N Allergic to Nickel

Y N Allergic to Plastic

Medical History

Has the child experienced any of the following medical problems?

Y N Abnormal Bleeding/ Hemophilia
Y N ADD/ADHD
Y N AIDS/HIV +
Y N Anemia
Y N Any Hospital Stays/Operations?
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Exposed to HIV, but Neg.
Y N Handicaps/Disabilities
Y N Hearing impairment
Y N Heart Murmur
Y N Hepatitis
Y N High Blood Pressure
Y N Hives
Y N Kidney Problems
Y N Liver Problems
Y N Low Blood Pressure
Y N Lupus
Y N Measles
Y N Mitral Valve Prolapse
Y N Mononucleosis
Y N Prosthetics
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)

Are the child's immunizations current? ❑ Yes ❑ No

Is there anything you would like to discuss with the Doctor in Private? ❑ Yes ❑ No

Please discuss any serious medical problems the child experiences/ed:

____

____

Does/did the child experience any of the following?

Y N Breast Fed
Y N Chewing on Objects
Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/finger Sucking
Y N Tongue/Cheek Sucking
Y N Tongue Thrust
Y N Used Pacifier

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control made by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____________________ Signature of Parent or Guardian

____________ Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

____________________ Signature of Dentist

____________ Date

Dentist's Comments: ____________________

____

Medical History Update

Has there been any change in your child's health status since their last visit? ❑ Yes ❑ No

If Yes, Please explain: ____________________

____

Has there been any change in your child's health status since their last visit? ❑ Yes ❑ No

If Yes, Please explain: ____________________

____

Parent /Guardian Signature ____ Date

Dentist Signature ____ Date

Parent /Guardian Signature ____ Date

Dentist Signature ____ Date