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: ______________________________________
First *Middle* *Last*
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: _________
Dentist Phone #: ( ) ______________________________

Emergency Contact:
Name: __________________ Phone #: ( ) _____________
Address: ____
____
City *State* *Zip Code*
Primary Language: ________________________________

Parent's Information

Person responsible for account: ______________________
Parent #1 Name: ___________________________________
☐ Mother/Father ☐ Step-Mother/Father ☐ Guardian
Address: (if different from Child's): ____________________
____
SS #: ____________________ DOB: ___________________
Work #: ( ) ______________ Cell #: ( ) _______________
Employer: ____
Employer's Address: __________________________________
____
City *State* *Zip Code*
If you have Dental Insurance for your Child, please fill out below:
Insurance Co. Name: __________________________________
Insurance Address: ___________________________________
____
City *State* *Zip Code*
Group #: ____

Parent's Marital Status: _______________________________
Parent #2 Name: ______________________________________
☐ Mother/Father ☐ Step-Mother/Father ☐ Guardian
Address: ____
____
SS #: ______________________ DOB: __________________
Work #: ( ) ______________ Cell #: ( ) _______________
Employer: ____
Employer's Address: ___________________________________
____
City *State* *Zip Code*
If you have Dental Insurance for your Child, please fill out below:
Insurance Co. Name: ___________________________________
Insurance Address: ____________________________________
____
City *State* *Zip Code*
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 your child to see the dentist today?

____

____

Question	Yes	No
Is your child currently in pain?	☐ Yes	☐ No
Does your child require antibiotics before dental treatment?	☐ Yes	☐ No
Has your child ever had a serious/difficult problem associated with previous dental treatment?	☐ Yes	☐ No
Is your child's water fluoridated?	☐ Yes	☐ No
Is your child taking fluoride supplements?	☐ Yes	☐ No
Has your child ever had any pain/ tenderness in his/her joint (TMJ)?	☐ Yes	☐ No
Does your child brush his/her teeth daily?	☐ Yes	☐ No
Does your child floss his/her teeth daily?	☐ Yes	☐ No
Is your child under a physician's care?	☐ Yes	☐ No

Child's Physician: ___________________________________
Phone #: ( ) ________________ Last Visit: ______________

Please describe your child's current physical health:
☐ Good ☐ Fair ☐ Poor

Please list any medications your child is currently taking:

____

____

Please list all foods & drugs that your child is allergic to:

____

____

Y N Allergic to Latex
Y N Allergic to Nickel
Y N Allergic to Metals
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 Artificial Bones/Joints/Valves
Y N Asthma
Y N Blood Pressure (High)
Y N Blood Pressure (Low)
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Diabetes
Y N Epilepsy/Seizures
Y N Exposed to HIV, but Neg.
Y N Handicaps/Disabilities
Y N Hearing Impaired
Y N Heart Murmur
Y N Hepatitis
Y N Hives
Y N Hospital Stay(s)
Y N Kidney Problems
Y N Liver Problems
Y N Lupus
Y N Measles
Y N Mitral Valve Prolapse
Y N Mononucleosis
Y N Operations
Y N Prosthetic Limb
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)

Are your child's immunizations current? ☐ Yes ☐ No
Is there anything you would like to discuss with Dr. Erin in private? ☐ Yes ☐ No
Please discuss any serious medical problems your child experiences/ed: ______________________________________

____

Does your child currently exhibit any of the following?

Y N Breast Fed
Y N Chewing on Objects
Y N Clench/Grind 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 Uses/Used Pacifier

Our office is HIPAA compliant & 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/Guardian *Date*

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: ____

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