CHILD FORM

Reed Family Dentistry

We would like to welcome you and 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.

1/ABOUT YOUR CHILD

TODAY'S DATE

CHILD'S NAME | NICKNAME

DATE OF BIRTH / / | AGE | SCHOOL | GRADE

HOME PHONE NUMBER | SOCIAL SECURITY NUMBER | EMAIL ADDRESS

HOME ADDRESS

CITY | STATE | ZIPCODE

2/WHO IS ACCOMPANYING THE CHILD TODAY?

NAME | RELATION

DO YOU HAVE LEGAL CUSTODY OF THE CHILD? : ☐ Yes ☐ No

WHO REFERRED YOU? | OTHER FAMILY MEMBERS SEEN BY US

PREVIOUS/PRESENT DENTIST | LAST VISIT DATE

PARENT'S MARITAL STATUS: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

3/MOTHER'S INFORMATION ☐ Mother ☐ Step Mother ☐ Guardian

NAME | DATE OF BIRTH / / | EMAIL

HOME PHONE | CELL PHONE

EMPLOYER | WORK NUMBER

SOCIAL SECURITY NUMBER

4/FATHER'S INFORMATION ☐ Father ☐ Step Father ☐ Guardian

NAME | DATE OF BIRTH / / | EMAIL

HOME PHONE | CELL PHONE

EMPLOYER | WORK NUMBER

SOCIAL SECURITY NUMBER

5/PERSON RESPONSIBLE FOR ACCOUNT

NAME _____ RELATION _____

BILLING ADDRESS _____ HOME NUMBER _____

EMPLOYER _____ SOCIAL SECURITY NUMBER _____

WORK NUMBER _____ EXT. _____

6/PERSON RESPONSIBLE FOR MAKING APPOINTMENTS

NAME _____ WORK NUMBER _____ EXT. _____

HOME NUMBER _____

7/PRIMARY DENTAL INSURANCE

INSURANCE COMPANY NAME _____ INSURANCE COMPANY ADDRESS _____

INSURANCE COMPANY PHONE _____ GROUP # (PLAN, LOCAL OR POLICY #) _____

POLICY OWNER'S NAME _____ RELATIONSHIP TO PATIENT _____

POLICY OWNER'S DOB ___/___/___ ID # _____ POLICY OWNER'S EMPLOYER _____

POLICY OWNER'S EMAIL ADDRESS _____ ORTHODONTIC COVERAGE? ☐ Yes ☐ No

8/SECONDARY DENTAL INSURANCE

INSURANCE COMPANY NAME _____ INSURANCE COMPANY ADDRESS _____

INSURANCE COMPANY PHONE _____ GROUP # (PLAN, LOCAL OR POLICY #) _____

POLICY OWNER'S NAME _____ RELATIONSHIP TO PATIENT _____

POLICY OWNER'S DOB ___/___/___ ID # _____ POLICY OWNER'S EMPLOYER _____

POLICY OWNER'S EMAIL ADDRESS _____ ORTHODONTIC COVERAGE? ☐ Yes ☐ No

9/WHY DID YOU BRING THE CHILD IN TODAY?

WHY DID YOU BRING THE CHILD IN TODAY?

HAVE YOU EVER HAD A SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK?: ☐ Yes ☐ No

IS THE CHILD'S WATER FLUORIDATED?: ☐ Yes ☐ No

IS THE CHILD TAKING FLUORIDATED SUPPLEMENTS?: ☐ Yes ☐ No

DOES OR HAS THE CHILD EXPERIENCED PAIN / DISCOMFORT IN YOUR JAW JOINT (TMJ / TMD)?: ☐ Yes ☐ No

DOES THE CHILD BRUSH DAILY?: ☐ Yes ☐ No

DOES THE CHILD FLOSS DAILY?: ☐ Yes ☐ No

10/MEDICAL HISTORY

CHILD'S PHYSICIAN

DATE OF LAST VIST

PLEASE DESCRIBE THE CHILD'S CURRENT PHYSICAL HEALTH: ☐ Good ☐ Fair ☐ Poor

HAS YOUR CHILD EVER TAKEN FOSAMAX OR ANY OTHER BISPHOSPHONATE?: ☐ Yes ☐ No

HAS YOUR CHILD EVER TAKEN PHEN-FEN? ☐ Yes ☐ No

PLEASE LIST ALL THE DRUGS THE CHILD IS CURRENTLY TAKING

PLEASE LIST ALL THE DRUGS / MATERIALS THE CHILD IS ALLERGIC TO

IS THE CHILD ALLERGIC TO ANY OF THE FOLLOWING?

Y	N		Y	N		Y	N	
☐	☐	Plastic	☐	☐	Metals / Nickel	☐	☐	Latex

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N		Y	N		Y	N	
☐	☐	Abnormal bleeding	☐	☐	Cancer	☐	☐	Hemophilia
☐	☐	ADD / ADHD	☐	☐	Congenital Heart Defect	☐	☐	Hepatitus
☐	☐	Allergies to any drugs	☐	☐	Convulsions / Epilepsy	☐	☐	HIV+ / AIDS
☐	☐	Any hospital stays	☐	☐	Diabetes	☐	☐	Kidney / Liver Problems
☐	☐	Any operations	☐	☐	Handicaps / Disabilities	☐	☐	Rheumatic / Scarlet Fever
☐	☐	Artifical Bones / Joints	☐	☐	Hearing Impairment	☐	☐	Sickle Cell Disease / Traits
☐	☐	Asthma	☐	☐	Heart Murmur	☐	☐	Tuberculosis (TB)

PLEASE EXPLAIN

DOES / DID THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

☐ Lip Sucking / Biting ☐ Nail Biting ☐ Nursing Battle Habits ☐ Thumb / Finger Sucking ☐ Nursing / Bottle Habits

10/NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

NAME PHONE

ADDRESS

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any change in my medical status. I authorize the dental staff to perofrm any necessary dental services that my child may need.

SIGNATURE DATE

The parent or guardian who accompanies the child is responsibile for payment at time of service unless prior arangements have been approved.

A/OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. INITIALS DATE

DOCTOR'S COMMENTS

B/MEDICAL HISTORY UPDATE

DATE	COMMENTS	SIGNATURE
DATE	COMMENTS	SIGNATURE
DATE	COMMENTS	SIGNATURE