Child Information

Marianna Baker, D.D.S.
Family Dentist

Today's Date_____

We would like to welcome you and your child to the office of Marianna Baker, D.D.S. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Child's Information

Name _____

Nickname_____ ☐Male ☐Female

Address _____

City/State/Zip _____

Birthday _____

SS# _____

Parent Information

Mother's name_____

Father's Name_____

Person responsible for making appointments _____

Whom may we thank for referring you?_____

_____

Person Responsible for Account

Name _____

Relation _____

Address _____

City/State/Zip _____

Birthday _____

SS# _____

Occupation _____

Employer _____

Employer Address _____

City/State/Zip _____

How Long There _____

Additional info we should know about your child _____

_____

Primary Insurance

Dental Insurance: ☐Yes ☐No

Policy Number _____

Company Name_____

Company Address _____

City/State/Zip _____

Phone _____

Insured Name _____

Insured SS#_____

Insured Birthday _____

Insured Employer _____

Employer Address _____

City/State/Zip _____

Relationship_____

Secondary Insurance

Dental Insurance: ☐Yes ☐No

Policy Number _____

Company Name_____

Company Address _____

City/State/Zip _____

Phone _____

Insured Name _____

Insured SS#_____

Insured Birthday _____

Insured Employer _____

Employer Address _____

City/State/Zip _____

Relationship_____

_____

The parent of guardian who accompanies the child is responsible for payment at time of service.
I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature_____Date_____

Child's Medical History

Does your child have a personal physician? ☐ Yes ☐ No

Physician's name_____

Phone number_____

Date of child's last visit _____

Is your child currently under care of the physician? ☐ Yes ☐ No

Please explain _____

_____

_____

Child's current physical health: ☐ Good ☐ Fair ☐ Poor

Does your child have any of the following habits?

☐ Lip Sucking / Biting
☐ Nail Biting
☐ Nursing Bottle Habits
☐ Thumb / Finger Sucking
☐ Other _____

_____

_____

Does your child have any loose teeth? ☐ Yes ☐ No

Does your child still have wisdom teeth? ☐ Yes ☐ No

Has your child ever had of the following medical problems?

☐ Abnormal Bleeding/Hemophilia
☐ ADD/ADHD
☐ AIDS/HIV+
☐ Anemia
☐ Any Operations
☐ Artificial Bones/Joints/Valves
☐ Asthma
☐ Blood Transfusion
☐ Cancer/Chemotherapy
☐ Colitis
☐ Congenial Heart Defect
☐ Diabetes
☐ Difficulty Breathing
☐ Epilepsy
☐ Fainting Spells
☐ Frequent Headaches
☐ Handicaps/Disabilities
☐ Hay Fever
☐ Hearing Impairment
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis
☐ Kidney Problems
☐ Liver Disease
☐ Lupus
☐ Mitral Valve Prolapse
☐ Psychiatric Problems
☐ Radiation Treatment
☐ Rheumatic/Scarlet Fever
☐ Seizures
☐ Sickle Cell Disease/Traits
☐ Sinus Problems
☐ Thyroid Problems
☐ Tuberculosis (TB)
☐ Ulcers
☐ Other _____

_____

_____

Child's Medications

Please list all prescription/over-the-counter drugs your child is currently taking _____

_____

Has your child ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Has your child ever taken Fen-phen? ☐ Yes ☐ No

Child's Allergies

Is your child allergic to any of the following?

☐ Aspirin ☐ Erythromycin ☐ Penicillin
☐ Codeine ☐ Jewelry / Metals ☐ Tetracycline
☐ Dental Anesthetic ☐ Latex
☐ Other _____

Child's Dental History

Why have you brough your child in today? _____

_____

Is your child currently in pain? ☐ Yes ☐ No

Does your child require antibiotics before for dental treatment? ☐ Yes ☐ No

Your child's current dental health is:
☐ Hard ☐ Medium ☐ Soft

Has your child ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Does your child floss daily? ☐ Yes ☐ No

Brush daily? ☐ Yes ☐ No

Type of bristles on your child's toothbrush?
☐ Hard ☐ Medium ☐ Soft

Has your child ever had gum treatment? ☐ Yes ☐ No

Do your child's gums ever bleed? ☐ Yes ☐ No

Ever itch? ☐ Yes ☐ No

Has your child ever had periodontal disease? ☐ Yes ☐ No

Does your child now or has your child ever experienced pain / discomfort in their jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Are your child's teeth sensitive to heat, cold, or anything else?

_____

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 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 on my child any necessary dental services that he/she may need during diagnosis and treatment, with my informed consent.

Signature_____Date_____