ARROWHEAD LAKES DENTISTRY

Welcome

THANK YOU FOR GIVING US THE OPPORTUNITY TO SERVE YOUR CHILD'S DENTAL NEEDS. PLEASE FILL OUT THIS FORM COMPLETELY.

CHILD'S NAME: ____________________ (LAST / FIRST / MI)

CHILD'S PREFERRED NAME: ____________ ☐ MALE ☐ FEMALE

BIRTHDATE ___/___/___ SS#: ____________

EMAIL: ____________

HOME ADDRESS: ____________ (STREET / APT NO.)

____________ (CITY / STATE / ZIP)

HOME # (___) ________ SCHOOL GRADE: ________

FULL TIME STUDENT? NO YES -- SCHOOL ATTENDING: ____________

WHO IS ACCOMPANYING THE CHILD TODAY?

NAME: ____________ RELATION: ________

DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? ☐ YES ☐ NO

WHERE & WHEN ARE BEST TIMES TO REACH YOU? ____________

WHOM MAY WE THANK FOR REFERRING YOU? ____________

OTHER FAMILY MEMBERS SEEN BY US: ____________

PARENT'S INFORMATION

☐ MOTHER ☐ STEP MOTHER ☐ GUARDIAN

NAME: ____________ BIRTHDATE ___/___/___

WORK # (___) ________ HOME # (___) ________

CELL # (___) ________

EMPLOYER: ____________

SS#: ____________ DRIVER LIC # ________

☐ FATHER ☐ STEP FATHER ☐ GUARDIAN

NAME: ____________ BIRTHDATE ___/___/___

WORK # (___) ________ HOME # (___) ________

CELL # (___) ________

EMPLOYER: ____________

SS#: ____________ DRIVER LIC # ________

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU:

NAME: ____________ REALTION: ________

WORK # (___) ________ HOME # (___) ________

ADDRESS: ____________ (STREET / APT NO.)

____________ (CITY / STATE / ZIP)

TODAY'S DATE ___/___/___

PERSON RESPONSIBLE FOR ACCOUNT: ☐ FATHER ☐ MOTHER

☐ OTHER: ____________

WORK # (___) ________ HOME # (___) ________

BILLING ADDRESS ____________ (STREET / APT. NO.)

____________ (CITY / STATE / ZIP)

RELATION: ________ SS#: ________

BIRTHDATE: ___/___/___ DRIVER LIC # ________

EMPLOYER: ____________

PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: ____________

INSURANCE CO. ADDRESS: ____________ (STREET)

____________ (CITY / STATE / ZIP)

INSURANCE CO. PHONE # (_____) ____________

GROUP # (PLAN, LOCAL OR POLICY#) ____________

INSURED'S NAME: ____________ RELATION: ________

INSURED'S BIRTHDATE: ___/___/___ INSURED ID# ________

INSURED'S EMPLOYER: ____________

EMPLOYER'S ADDRESS: ____________ (STREET)

____________ (CITY / STATE / ZIP)

SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: ____________

INSURANCE CO. ADDRESS: ____________ (STREET)

____________ (CITY / STATE / ZIP)

INSURANCE CO. PHONE # (_____) ____________

GROUP # (PLAN, LOCAL OR POLICY#) ____________

INSURED'S NAME: ____________ RELATION: ________

INSURED'S BIRTHDATE: ___/___/___ INSURED ID# ________

INSURED'S EMPLOYER: ____________

EMPLOYER'S ADDRESS: ____________ (STREET)

____________ (CITY / STATE / ZIP)

Has your child ever had any of the following diseases or medical problems? (Please circle the option that applies)

Yes	No	Abnormal Bleeding	Yes	No	Fainting Spells
Yes	No	ADD / ADHD	Yes	No	GERD
Yes	No	Allergies	Yes	No	Handicaps / Disabilities
Yes	No	Anemia	Yes	No	Hearing Impairment
Yes	No	Any Hospital Stays	Yes	No	Heart Disease
Yes	No	Any Operations	Yes	No	Hepatitis
Yes	No	Artificial Joints	Yes	No	HIV+ or AIDS
Yes	No	Asthma	Yes	No	Injury to Head or Face
Yes	No	Blood Disease	Yes	No	Kidney Problems
Yes	No	Breathing Problems	Yes	No	Liver Disease
Yes	No	Cancer-Chemotherapy	Yes	No	Psychiatric Problems
Yes	No	Circulatory Problems	Yes	No	Radiation Therapy
Yes	No	Colitis	Yes	No	Rheumatic Fever
Yes	No	Congenital Heart Disease	Yes	No	Seizures
Yes	No	Cosmetic Surgery	Yes	No	Sinus Problems
Yes	No	Diabetes	Yes	No	Thyroid Problems
Yes	No	Emphysema	Yes	No	Tuberculosis (TB)
Yes	No	Epilepsy			

Please list any serious medical conditions that your child have ever had or explain any "yes" answers from the list above: ______

____

____

Is your child allergic or had an adverse reaction to any of the following?

Yes	No	Aspirin	Yes	No	Jewelry / Metals
Yes	No	Codeine	Yes	No	Latex
Yes	No	Dental Anesthetics	Yes	No	Penicillin
Yes	No	Erythromycin	Yes	No	Tetracycline

Please list any other drugs or materials that your child is allergic or has had an adverse reaction to: ______________________________

____

Is your child taking any prescription drug, over-the-counter medication, or supplement?

Please list each one ______________________________

____

____

Your child's current physical health is (please circle):

Good Fair Poor

Yes No Has a physician recommended that your child needs to take antibiotics before dental treatment?

Yes No Is your child currently under a physician's care?

If so, please explain: ______________________________

____

Physician's Name: ______________________________

Phone #: (____) ___ ________

Dental History

Why did you bring your child to the dentist today? ______________

____

____

How would you rate your child's current dental health?

Good Fair Poor

Date of last dental visit: ______________

Concerning your child:

Yes	No	Currently in pain?
Yes	No	Gums ever bleed?
Yes	No	Teeth sensitive to hot, cold, or chewing?
Yes	No	Any complication with any previous dental work?
Yes	No	Ever had any head, neck, or jaw injury?
Yes	No	Ever had orthodontic treatment (braces)?
Yes	No	Ever had any oral surgery?
Yes	No	Humb sucking or other oral habit?
Yes	No	Mouth breather?
Yes	No	Like to change anything about the smile?

If so, please explain: ______________________________

How many times a day do you brush your teeth? ______________

How many times a week do you floss? ______________

Is there anything else you want us to know about your child's medical and dental health? ______________

____

____

____

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 medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.

______________________________ ________

Signature of Parent or Guardian Date