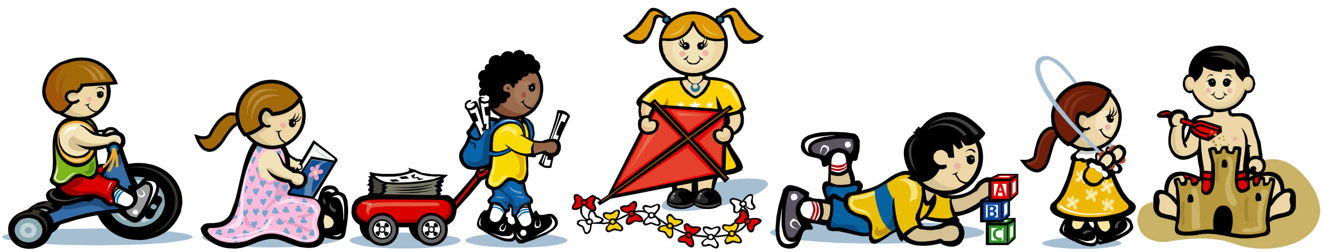

Welcome to Children's Dentistry

Childs Name: (full name) ____________________________ Nickname: __________

Sex: M F Date of Birth: __________________ Age: ____________________

Have we seen any children in your family before: __________ Names: __________________

Whom may we thank for referring you to our office: ______________________________

Internet Hometown Values Galaxy Postcard Phone Book

Medical Information

Is your child under doctor's care now: ______________ For what reason: ________________

Is your child taking any medications or drugs: ______ What kind: ____________________

Has your child ever been hospitalized: _____ When: __________ Reason: _______________

Has your child had any difficulty with any of the following?

YES	NO		YES	NO		YES	NO	
___	___	Premature Birth	___	___	Bleeding	___	___	Seizures
___	___	Brain Injury	___	___	Cerebral Palsy	___	___	AIDS/HIV
___	___	Heart Defect	___	___	Anemia	___	___	Asthma
___	___	Cancer/Tumors	___	___	Speech Disorder	___	___	Liver
___	___	Bone Disorder	___	___	Hearing Problems	___	___	Diabetes
___	___	Rheumatic Fever	___	___	Hepatitis	___	___	Gag Reflex
___	___	Kidney Problems	___	___	Earaches	___	___	Latex Allergy
___	___	Jaw Problems	___	___	Hyper Active ADHD	___	___	Tuberculosis
___	___	Cleft/ Lip Palate	___	___	Respiratory Problems	___	___	Leukemia

Allergies to medications: ____

Does your child have any emotional or behavioral problems: ________________________

Dental Information

Reason for visit today: ____________________________ Date of last dental visit: _________

How was your child during his/ her last visit: ____________________________________

Former Dentist: __________________________ City, State: ___________________________

Was your child breast or bottle fed: ____________________ Until what age: ____________

Does your child have any mouth habits, such as finger/ thumb sucking: __________________

Has your child had any injuries to his teeth or mouth: ______ If so explain: ______________

Does your child brush and floss regularly: ____ How often do they brush: ______ Floss: _____

How may we help to make this visit a positive experience for your child: ________________

____

General Information

Father: (full name) ____________________ Date of Birth: __________
Address: ______________________________
City: ______________ State: ____ Zip: ______ Marital Status: ________
Social Security #: ____-____-______ Drivers License #: ______________
Email: ______________________________
Home Phone: ( ) ______________ Cell: ( ) ______________
Employer: ____________________ Work Phone: ( ) __________

Mother: (full name) ____________________Date of Birth: __________
Address: ______________________________
City: ______________ State: ____ Zip: ______ Marital Status: ________
Social Security #: ____-____-______ Drivers License #: ______________
Email: ______________________________
Home Phone: ( ) ______________ Cell: ( ) ______________
Employer: ____________________ Work Phone: ( ) __________

What is the best number to contact you: ______________________

Name of next of kin, neighbor: (in case of emergency) ______________
Relationship to child: ____________ Phone: ( ) ______________

Insurance Information

PRIMARY:
Name of Insurance: ____________________ Subscriber: __________
Address: ____________________ City: ______________ State:
____ Zip: __________ Phone: ( ) __________ Group #: ______
Subscribers ID: ______________ Subscribers Employer: __________

SECONDARY:
Name of Insurance: ____________________ Subscriber: __________
Address: ____________________ City: ______________ State:
____ Zip: __________ Phone: ( ) __________ Group #: ______
Subscribers ID: ______________ Subscribers Employer: __________

Consent

I hereby authorize Dr. Mark L. Nelson, D.D.S, to perform all procedures as determined necessary and/or advisable for the examination and diagnosis of the above named patient.

____________________ __________ ______________
Signature of Responsible Party Date Relationship