Welcome to Children's Dentistry

Child's full Name_____ Nick Name_____
Sex: M☐F☐ Date of Birth_____ Age _____
Have we seen any children in your family before? Y☐N☐Names _____
Whom may we thank for referring you to our office: _____

☐Internet/Google ☐Insurance ☐Social Media ☐Flyer

Medical Information

Yes	No		Yes	No		Yes	No	
___	___	Premature Birth	___	___	Bleeding	___	___	Seizures
___	___	Brain Injury	___	___	Cerebral Palsy	___	___	Asthma
___	___	Cancer/Tumors	___	___	Speech Disorder	___	___	Liver
___	___	Bone Disorder	___	___	Hearing Problems	___	___	Diabetes
___	___	Rheumatic Fever	___	___	Hepatitis	___	___	Gag Reflex
___	___	Kidney Problems	___	___	Earaches	___	___	LatexAllergy
___	___	Jaw Problems	___	___	Hyper Active ADHD	___	___	Leukemia
___	___	Gastro Disease	___	___	Autisim	___	___	Anemia
___	___	Hypertension	___	___	Lung/ Respiratory Prob.	___	___	HIV/AIDS
___	___	Turberculosis	___	___	Heart Disease	___	___	Mental Illness
___	___	Sensory Disorder	___	___	Other: _____			

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 of 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
_____
How often does your child brush _____ Floss _____
How can we help to make this visit a positive experience _____

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**