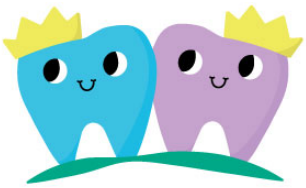

Children's Dentistry OF COUNCIL BLUFFS

40 Northcrest Drive, Suite 1 • Council Bluffs, IA 51503 • (712) 328-9605 • drjoe@childrensdentistryofCB.com

Tell Us About Your Child

Today's Date: _____ Child's Home Phone #: _____

Child's Last Name: _____ First Name: _____ Nickname: _____

Child's Date of Birth: _____ ☐ Male ☐ Female

Child's Home Address: _____City:_____State: _____ Zip: _____

Whom may we thank for referring you to our office? _____

Parent's Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single ☐ Partnered

Mother Name: _____ Social Security #:_____

Home Phone#: _____ Work Phone#: _____ Cell Phone #: _____

Birthdate: _____ E-mail Address: _____

Address: _____

City: _____ State: _____ Zip: _____ Employer: _____

Father Name: _____ Social Security #:_____

Home Phone#: _____ Work Phone#: _____ Cell Phone #: _____

Birthdate: _____ E-mail Address: _____

Address: _____

City: _____ State: _____ Zip: _____ Employer: _____

Insurance Information

Primary Insurance Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name:_____ Phone #:_____ Group #:_____

Insurance Co. Address:_____

City: _____ State: _____ Zip: _____

Insured's Name:_____ Relationship to Patient:_____

Insured's Birthdate:_____ Insured's ID #:_____ Insured's Employer:_____

Secondary Insurance Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name:_____ Phone #:_____ Group #:_____

Insurance Co. Address:_____

City: _____ State: _____ Zip: _____

Insured's Name:_____ Relationship to Patient:_____

Insured's Birthdate:_____ Insured's ID #:_____ Insured's Employer:_____

Dental History

First Name: _____ Last Name: _____ Date of Birth: _____

Is the child currently in pain? ☐ Yes ☐ No What is the primary reason for today's visit?_____

Has the child experienced problems with previous dental work? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

☐ Previous ☐ Present Dentist:_____ Date of Last Visit: _____

Why did you leave your previous dentist?:_____

What did you ***like*** most about any dentist you have seen?:_____

What did you ***dislike*** most about any dentist you have seen?:_____

Does/did the child have any of the following habits?

☐ Yes ☐ No Lip Sucking/Biting	☐ Yes ☐ No Clenching/Grinding Teeth	☐ Yes ☐ No Tongue/Cheek Biting
☐ Yes ☐ No Mouth Breather	☐ Yes ☐ No Nail Biting	☐ Yes ☐ No Thumb/Finger Sucking
☐ Yes ☐ No Used Pacifier	☐ Yes ☐ No Speech Problems	☐ Yes ☐ No Chewing on Objects
☐ Yes ☐ No Nursing Bottle Habits	☐ Yes ☐ No Tongue Thrust	☐ Yes ☐ No Breast Fed

Medical History

Child's Physician:_____ Phone #:_____ Date of Last Visit:_____

Address:_____

Is the child currently under the care of a physician? ☐ Yes ☐ No Please explain:_____

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor ***Are immunizations current?*** ☐ Yes ☐ No

Please list all of the drugs that the child is currently taking:_____

Is your child allergic to any of the following: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ **Latex** ☐ Local Anesthetics

Does your child have any medical conditions that require Pre-Med? ☐ Yes ☐ No

Has the child had/experienced any of the following:

☐ Yes ☐ No Abnormal Bleeding	☐ Yes ☐ No Congenital Heart Defect	☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Rheumatic Fever	☐ Yes ☐ No AIDS/HIV+	☐ Yes ☐ No Convulsions
☐ Yes ☐ No Hives	☐ Yes ☐ No Scarlet Fever	☐ Yes ☐ No Allergies
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Kidney Problems	☐ Yes ☐ No Sickle Cell Anemia
☐ Yes ☐ No Anemia	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Liver Problems
☐ Yes ☐ No Skin Rash	☐ Yes ☐ No Any Hospital Stay/Operations	☐ Yes ☐ No Handicaps/Disabilities
☐ Yes ☐ No Low Blood Pressure	☐ Yes ☐ No Tonsillitis	☐ Yes ☐ No Asthma
☐ Yes ☐ No Hearing Impairment	☐ Yes ☐ No Lupus	☐ Yes ☐ No Tuberculosis (TB)
☐ Yes ☐ No Blood Transfusion	☐ Yes ☐ No Heart Murmur	☐ Yes ☐ No Measles
☐ Yes ☐ No Cancer	☐ Yes ☐ No Hemophilia	☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Chicken Pox	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Mononucleosis

Please discuss any serious medical problems the child experiences/ed:_____

_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign the Doctor to all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

If you understand the above and all of your questions have been answered, check here: ☐

Name: _____ Date: _____