Children's Dental FunZone!
Children's Dentistry and Orthodontics

Welcome

Please take a few minutes to fill out the questionnaire.
Thank you very much for your attention

Patients Name: _____ Nickname: _____
Last First MI

Date of Birth: _____ Gender: _____

Patients Address: _____City: _____ State: _____ Zip: _____

Parents Cell Phone: _____ E-mail: _____

Home Phone: _____Parents Work Phone: _____

In case of emergency, contact _____Phone: _____

Whom may we thank for referring you? _____

Who Is Accompanying the Patient Today? Name: _____ Relation: _____

Do you have legal custody of this patient? Yes / No If no documents are required-(Appointed by court)

Parents Marital Status (please circle): Single Married Widowed Divorced Separated

Person Responsible for Account

Name: _____ Relation: _____

Name: _____ Relation: _____
Address (If Different): _____ City: _____ State: _____ Zip: _____

Parents Cell Phone: _____ E-mail: _____

Home Phone: _____Parents Work Phone: _____

Name of Employer: _____DL#: _____ SS#: _____

Who is responsible for making appointments? Name: _____ Cell Phone: _____

Primary Dental Insurance
Insurance Co Name: _____
Insurance Co Address: _____
Insurance Co Phone: _____
Group #: _____
Policy Owners Name: _____
Relationship to Patient: _____
Policy Owner Birthdate: _____ ID#: _____

Orthodontic Coverage? Yes/No

Secondary Dental Insurance
Insurance Co Name: _____
Insurance Co Address: _____
Insurance Co Phone: _____
Group #: _____
Policy Owners Name: _____
Relationship to Patient: _____
Policy Owner Birthdate: _____ ID#: _____

Orthodontic Coverage? Yes/No

Dental History

Reason for Today's Visit _____ is this your child's first visit to the dentist? Yes / No

Date of Last Dental Care _____ Date of Last X-rays _____

Does your child have any of the following?

- ☐ **Lip Sucking / Biting**
- ☐ **Speech Problems**
- ☐ **Nail Biting**
- ☐ **Thumb/Finger Sucking**
- ☐ **Mouth Breather**
- ☐ **Tongue Thrust**
- ☐ **Nursing Bottle Habits**
- ☐ **Clenching/ Grinding Teeth**

Does the patient brush his / her teeth daily? Yes / No

Does the patient floss his / her teeth daily? Yes / No

Has the patient ever had a serious / difficult problem associated with previous dental work? Yes / No

Has the patient ever had any pain / tenderness in his / her jaw joint (TMJ/TMD)? Yes / No

Has the patient ever had orthodontic treatment (braces)? Yes / No

Medical History

Is the patient currently under the care of a physician? Yes / No

Describe the patient's current physical health: Good Fair Poor

Has the patient ever been prescribed Fosamox or any other bisphosphonate? Yes / No If so, When? _____

List all prescription / over the counter or herbal supplement drugs that the patient is currently taking:

_____,_____._____,_____

(PLEASECHECK AT LEAST ONE (1) OF THE BOXES)

Has the patient ever had any of the following medical problems? Please check at least one of the boxes.

- ☐ **Abnormal Bleeding**
- ☐ **ADD / ADHD**
- ☐ **Operations / Surgery**
- ☐ **Artificial Bones / Joints**
- ☐ **Asperger Syndrome**
- ☐ **Asthma**
- ☐ **Cancer**
- ☐ **Congenital Heart Defect**
- ☐ **Convulsions / Epilepsy**
- ☐ **Diabetes**
- ☐ **Handicaps / Disabilities:_____**
- ☐ **Hearing Impairment**
- ☐ **Heart Murmur**
- ☐ **Hemophilia**
- ☐ **Hepatitis**
- ☐ **HIV+ / AIDS**
- ☐ **Hospital Stays**
- ☐ **Kidney / Liver Problems**
- ☐ **Rheumatic / Scarlet Fever**
- ☐ **Sickle Cell Disease / Traits**
- ☐ **Tuberculosis (TB)**

☐ **No Medical problems**

Discuss any serious medical problems that the patient has had: _____

Adolescent Women:

- ☐ **Are you taking oral contraceptive?**
- ☐ **Are you pregnant now or think you may**
- ☐ **Are you nursing?**

Allergies *(Please check at least one (1) of the boxes)*

- ☐ **Latex** **Penicillin _____**
- ☐ **Metal** **Other_____**
- ☐ **Nickel** **Food_____**
- ☐ **Plastic**
- ☐ **None**

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I hereby authorize the Dentists and staff at Children's Dental FunZone to perform diagnostic aids including X-rays, models and photographs as appropriate to make a thorough diagnosis of the patient's dental needs. I authorize the use of this signature on all insurance submissions. I authorize the dentists to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that I will be charged 24% APR for any past due balances over 60 days.

I consent Children's Dental FunZone the using my cell phone number to call or and text regarding appointments, insurance, and my account. I understand that I can withdraw my consent at any time. _____ (initial)

_____ _____ _____

Name of parent/legal guardian (please print) **Signature** **Date**

_____ _____ _____

Review Medical History/ Comments **Dentist Signature** **Date**