VILLAGE DENTAL CENTER

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOUR CHILD

Name:_____

Birthdate:_____Age:_____

M__F__ School/Grade_____

_____

Child's Address:_____

_____

Child's Home # (___)_____

Mother's Name_____

Mother's Wk# (___)_____

Father's Name_____

Father's Wk# (___)_____

Whom may we thank for referring you?

_____

Person Responsible for Account:

_____

(Name) (Relationship)

Billing Address:_____

_____

DENTAL INSURANCE

Primary Dental Insurance:

Insurance Co:_____

Insurance Address:_____

_____

Group/Policy #_____

Insured's Name:_____

Insured's SS#:_____

Employer_____

Secondary Dental Insurance:

Insurance Co:_____

Insurance Address:_____

_____

Group/Policy #_____

Insured's Name:_____

Insured's SS#:_____

Employer_____

ABOUT YOUR CHILD'S DENTAL HEALTH

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

Has your child ever had a serious/difficult problem associated with previous dental treatment?

_____

Has your child ever had any pain/tenderness in the the jaw joint (TMJ)? _____

Is this your child's first visit? _____If not, How long since the last examination?_____

What was done at that time?_____

How often does your child brush?_____ Does he/she floss?_____

Does your child have a habit of thumb/finger sucking?_____

Does your child's gums bleed when he/she brushes?_____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL DIFFICULTIES?

Please circle

Y N Heart Attack/Stroke
Y N Cancer/Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV+/AIDS
Y N Heart Surgery/Pacemaker
Y N Shingles
Y N Mitral Valve Prolapse
Y N Kidney problems
Y N Artificial Joints
Y N Artificial Valves
Y N Sinus Trouble
Y N High/Low Blood Pressure
Y N Fever Blisters
Y N Severe/Frequent Headaches

Y N Psychiatric problems
Y N Epilepsy/ Seizures/ Fainting
Y N Diabetes/ Tuberculosis
Y N Drug/Alcohol abuse
Y N Venereal Disease
Y N Hemophilia/Abnormal bleeding
Y N Ulcers/Colitis
Y N Congenital Heart Defect
Y N Anemia/Radiation Treatment
Y N Asthma/ Arthritis
Y N Difficulty Breathing
Y N Recent Hospitalization
Y N Hepatitis/ Liver Disease
Y N Blood Transfusion
Y N Emphysema/Glaucoma

List any other conditions_____

_____

IS YOUR CHILD ALLERGIC TO: Y N Penicillin Y N Codeine Y N Latex
Y N Aspirin Y N Dental Anesthetics Y N Erythromycin Y N Other
Please List_____

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 with my informed consent that I may need during diagnosis and treatment.

_____

Signature (Parent) Date