



**Welcome to our practice!** We strive to make your child's visit pleasant and comfortable. Our goal is to teach your child oral habits which will help maintain a beautiful smile for a lifetime.

## Your Child

Child's Name \_\_\_\_\_ Nick Name \_\_\_\_\_  
Sex:  Male  Female Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
SS#/SIN \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
Child's Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

## 1st Parent

Name \_\_\_\_\_ E-mail \_\_\_\_\_  
Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
SS#/SIN \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

## 2nd Parent

Name \_\_\_\_\_ E-mail \_\_\_\_\_  
Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
SS#/SIN \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

## Parent's Marital Status

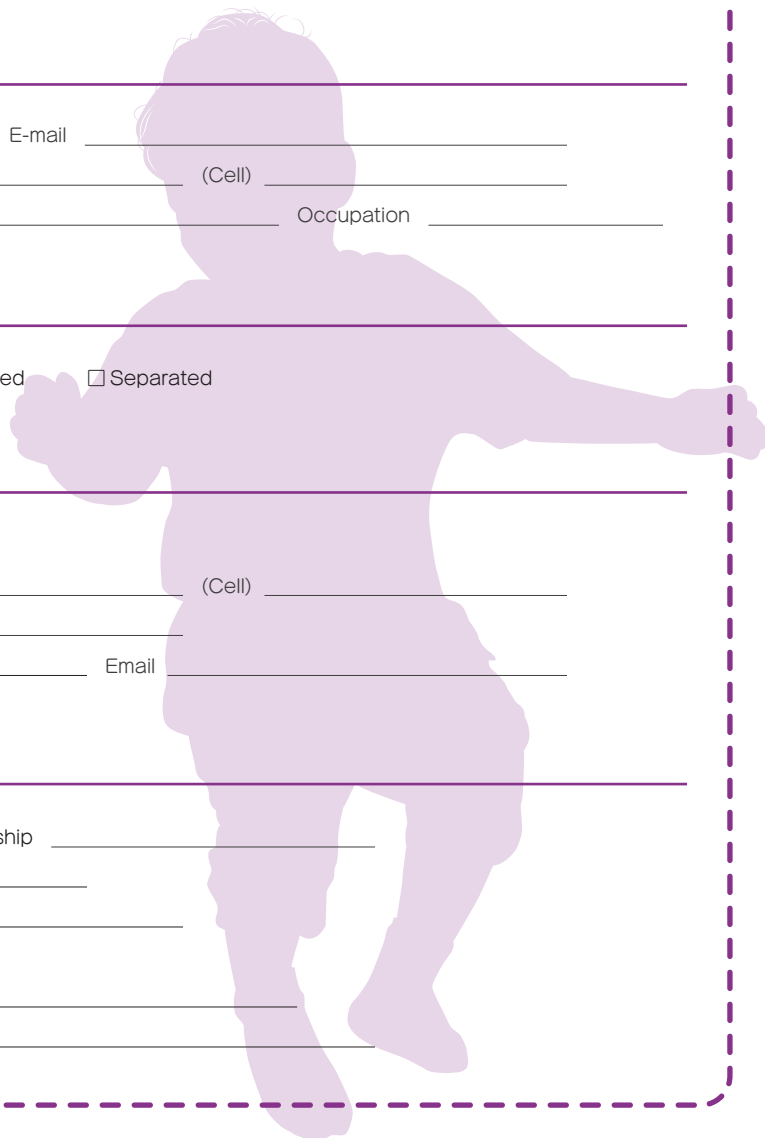
Single  Married  Divorced  Widowed  Separated

## Who is responsible for making appointments?

Name \_\_\_\_\_  
Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
At which number shall we contact you? \_\_\_\_\_  
Best time to call: (Date) \_\_\_\_\_ (Time) \_\_\_\_\_ Email \_\_\_\_\_

## Primary Dental Insurance

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_ Date Emp. \_\_\_\_\_  
Ins. Company \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Ins. Company Address \_\_\_\_\_





# Health History

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

## Health History

Has your child had difficulty with previous visits? \_\_\_\_\_

Does your child have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ? \_\_\_\_\_

Is your child taking any medication? If so please list: \_\_\_\_\_

Has your child ever had any of the following:

- |            |                              |                             |                         |                              |                             |
|------------|------------------------------|-----------------------------|-------------------------|------------------------------|-----------------------------|
| Asthma     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Congenital Heart Defect | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Handicaps/Disabilities  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV/AIDS   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Convulsions/Epilepsy    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hemophilia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Abnormal Bleeding       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Murmur            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please explain any medical problems that your child has:

\_\_\_\_\_

\_\_\_\_\_

## Child's Habits

How often does your child brush? \_\_\_\_\_ How often does your child floss? \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Previous Dentist \_\_\_\_\_

Child's Physician \_\_\_\_\_ Physician's Phone Number \_\_\_\_\_

Child's Birthdate \_\_\_\_\_

Is your child's water fluoridated?  Yes  No Does your child take fluoride supplements?  Yes  No

Does your child:

- |                                  |                              |                             |                |                              |                             |
|----------------------------------|------------------------------|-----------------------------|----------------|------------------------------|-----------------------------|
| Suck thumb/finger                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suck/Bite lips | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chew hard objects(Pencils, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Grind Teeth    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Clench jaws                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                |                              |                             |

## Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or other health practitioners. I hereby authorize the office of Dr. Ruby Gelman to perform the examination and after explanation, any and all treatment for the above named child including radiographs if indicated and consent to such methods, drugs and agents that may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent/guardian if minor \_\_\_\_\_ Date \_\_\_\_\_

## Dentist Review

\_\_\_\_\_

Date \_\_\_\_\_

Signed Dr. \_\_\_\_\_

## Health History Update

Date \_\_\_\_\_

Comments \_\_\_\_\_

Signature \_\_\_\_\_