Welcome! Thank you for choosing Dentistry For Children and Families. It is our goal to provide your child with the best possible dental care. To help us meet all of your possible dental health needs, please fill out this form. If you have any questions, please ask.

Child/Minor Information (Confidential)

Name of Minor/Child_________________________ Date ________________________ SS/HIC/Patient ID___________

Gender: Male ☐ Female ☐ Birthdate____________________Age______ Cell Phone (_____)__________________

Nickname______________________________________Social Security # ______________________________

Address_______________________________________City____________________ State_________ Zip_____________

Mailing Address_________________________________City____________________ State_________ Zip_____________

Name of School____ School Phone Number (____)________________

Name of Employer____ Work Phone(_____)__________________

Person Financially Responsible____________________Home Phone (____)_____________ Work Phone (____)_________

Whom may we thank for referring you? ____

Insurance Information

Father/Guardian's Name ____ Email ______________________________

Birthdate ______________________ Social Security #____________________Phone Number (____)________________

Employer____ Work Phone (_____)______________________

Do you have dental insurance coverage for minor/child? No ____Yes____Plan Name______________________________

Insurance Phone Number_____________________________ Group #___________________ Policy #______________

Insurance Company Address__________________________City___________________ State_______ Zip____________

Mother/Guardian's Name____ Email _______________________________

Birthdate ______________________ Social Security #____________________Phone Number (____)________________

Employer____ Work Phone (_____)______________________

Do you have dental insurance coverage for minor/child? No____Yes____ Plan Name______________________________

Insurance Phone Number_____________________________ Group #___________________ Policy #______________

Insurance Company Address__________________________City___________________ State_______ Zip____________

Medical History

Minor/Child's Physician____________________________________ Date of Last Physical__________________________

Results of Physical_____________________________City,State___________________ Phone (____)________________

Is child/minor on any medications? No ____Yes____ Medications____

Has the child/minor ever been hospitalized? No____Yes____ Has the child/minor had any surgeries? No____Yes____

Please list any allergies____

Does minor/child bleed excessively when cut? No____ Yes ____

Has child/minor had any history or difficulty with any of the following? If yes, please check.

____AIDS/HIV
____Anemia
____Asthma
____Bladder Problems
____Cancer
____Cerebral Palsy
____Chicken Pox
____Convulsions
____Diabetes
____Drug/Alcohol Abuse

____Epilepsy
____Fainting
____Hearing Problems
____Heart Problems
____Hepatitis
____Kidney Disease
____Liver Disease
____Measles
____Mononucleosis
____Mumps

____Rheumatic Fever
____Sinus Problems
____Thyroid Disease
____Tuberculosis
____Other

Please list any other medical conditions _______________
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