CHILD PATIENT FORM

EverGrins
DENTAL + ORTHO

PATIENT INFORMATION

Child's Name _____

Nickname _____ Birthday _____ Age _____ ○ Male ○ Female

Home Address _____ City _____ State _____ Zip _____

School _____ Grade _____

Referred to Our Office by _____

PARENT INFORMATION

Guardian #1 Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Home Number _____

Cell Phone Number _____

E-mail Address _____

Occupation _____ Employer _____

Work Number _____

Guardian #2 Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Home Number _____

Cell Phone Number _____

E-mail Address _____

Occupation _____ Employer _____

Work Number _____

Who does the child live with?

○ Guardian 1 ○ Guardian 2 ○ Guardian 1 and 2

Other _____

PRIMARY INSURANCE

Insurance Co. _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Co. Phone _____

Group/Policy# _____

Name of Policy Owner _____

Date of Birth _____

Social Security Number _____

Employer _____

SECONDARY INSURANCE

Insurance Co. _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Co. Phone _____

Group/Policy# _____

Name of Policy Owner _____

Date of Birth _____

Social Security Number _____

Employer _____

WHO IS ACCOMPANYING THE PATIENT TODAY?

Name _____

Relationship _____

Do you have legal custody of this child? ○ Y ○ N

PERSON RESPONSIBLE FOR ACCOUNT

Name _____

Relationship _____

Primary Number to Confirm Appointments _____

CONTACT CONSENT

Cell Phone Consent

"I consent to the dental practice using my cell phone number to (choose one or both) CALL or TEXT regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time."

Cell Phone Number _____ Initials _____

Telephone Message Consent

"I understand brief messages from the dental practice may be left on my home/cell phone or with anyone who answers the telephone at my home unless I have provided the practice with alternative instructions for communication."

Telephone Number _____ Initials _____

CHILD PATIENT FORM CONTINUED

SOCIAL AND BEHAVIOR

Has the child had a previous unfavorable or fearful dental or medical experience? ○ Y ○ N

If yes, please describe _____

How would you best rate your child's temperament? _____

Child's Favorite Color/Toy/Movie _____

DENTAL HISTORY

Reason for Today's Visit _____

Has the child been to a dentist before? ○ Y ○ N

Date of Last Dental Visit _____

Date of Last Dental X-rays _____

Previous Dentist _____

How may we help make this visit a positive experience for your child?

_____

_____

Has the child experienced any injuries to the teeth, mouth or jaws? ○ Y ○ N

Does the child have any of the following habits?

☐ Suck Thumb/Finger
☐ Suck/Bite Lips
☐ Bite/Chew Nails
☐ Use Pacifier
☐ Breast Feeding-Until Age _____
☐ Bottle Feeding-Until Age _____
☐ Clench/Grind Teeth
☐ Mouth Breather

DENTAL HABITS

Does the child brush his/her teeth daily? ○ Y ○ N

Is the child's toothpaste fluoridated? ○ Y ○ N

Does the child floss his/her teeth daily? ○ Y ○ N

Does the child use mouthwash? ○ Y ○ N

Do you brush your child's teeth? ○ Y ○ N

What type of water does the child drink?

☐ Tap ☐ Filtered ☐ Bottled

Does the child take fluoride supplements? ○ Y ○ N

How many snacks between meals per day? _____

CHILD'S PHYSICIAN

Address _____

Phone _____

Date of Last Visit _____

HEALTH HISTORY

Are immunizations current? ○ Y ○ N

HAS YOUR CHILD BEEN DIAGNOSED AND/OR TREATED FOR ANY OF THE FOLLOWING?

Abnormal Bleeding/Hemophilia	○ Y	○ N
ADD/ADHD	○ Y	○ N
Allergies or Hay Fever	○ Y	○ N
Asthma/Reactive Airway Disease	○ Y	○ N
Autism/ASD	○ Y	○ N
Bone/Joint Problems	○ Y	○ N
Cancer/Tumor/Leukemia	○ Y	○ N
Cleft Lip and/or Palate	○ Y	○ N
Congenital Heart Defect	○ Y	○ N
Diabetes	○ Y	○ N
Disabilities/Special Needs	○ Y	○ N
Hearing/Vision Impairment	○ Y	○ N
Heart Disease/Murmur	○ Y	○ N
HIV+/AIDS/Immune Disorder	○ Y	○ N
Kidney/Liver Problems	○ Y	○ N
Rheumatic/Scarlet Fever	○ Y	○ N
Sickle Cell Disease/Trait	○ Y	○ N
Seizures/Epilepsy/Convulsions	○ Y	○ N
Stomach/GI Disorders	○ Y	○ N
Tuberculosis	○ Y	○ N

DOES THE CHILD OF A HISTORY OF THE FOLLOWING?

☐ Premature Birth
☐ Hospitalization/Operation
☐ Allergies to Latex
☐ Serious Illness
☐ Allergies to Medications
☐ Food Allergies

List Allergies: _____

_____

Current Medications _____

_____

Is there anything else regarding your child's physical, mental, or emotional health that you feel should be brought to the doctor's attention?

_____

_____

_____

Our office is committed to the highest standards of infection control mandated by WISHA, the WSDA, and the ADA. I understand the information I have given is true and correct to the best of my knowledge, that it will be held in the strictest of confidence. I grant this office permission to provide my child's dental treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete treatment, including diagnostic radiographs. I understand it is my responsibility to inform the office of any changes in my child's health or medications.

_____ Name of Parent or Guardian

_____ Signature

_____ Date

_____ Doctor's Signature

_____ Date