

# Welcome

## Dentistry for Children Dr. Cheryl Higer

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### 1. Tell Us About Your Child

Child's Name \_\_\_\_\_  
Last First Mi

Nickname \_\_\_\_\_  Male  Female

Siblings that we treat \_\_\_\_\_

Child's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age \_\_\_\_\_

Child's Home # (\_\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Which School does the child attend? \_\_\_\_\_

Child's Interests: \_\_\_\_\_

### 2. Dental History

Is this your child's first visit to the dentist? \_\_\_\_\_

If not, how long since the last visit to the dentist? \_\_\_\_\_

Were any x-rays taken at previous dental visits? \_\_\_\_\_

Have there been any injuries to the teeth, face or mouth? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Why did you bring the child to the dentist today? \_\_\_\_\_

Does the child have any of the following habits?

Lip Sucking / Biting   Nail Biting

Nursing / Bottle Habits   Thumb / Finger Sucking

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

If yes, please explain \_\_\_\_\_

Is the child's water fluoridated?  Yes  No

Is the child taking fluoride supplements?  Yes  No

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

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

Floss his / her teeth daily?  Yes  No

3. Who may we thank for referring you to our office?  
 \_\_\_\_\_

### 4. Health History

Has the child ever had any of the following conditions?

- |  |  |
|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Allergies to any Drugs:<br><i>(please see below)</i> | <input type="checkbox"/> <input type="checkbox"/> Epilepsies / Seizures        |
| <input type="checkbox"/> <input type="checkbox"/> Allergies to Latex                                   | <input type="checkbox"/> <input type="checkbox"/> Hay Fever                    |
| <input type="checkbox"/> <input type="checkbox"/> Allergies (Other Known):<br>_____                    | <input type="checkbox"/> <input type="checkbox"/> Anemia / Blood Disorders     |
| <input type="checkbox"/> <input type="checkbox"/> Any Hospital Stays                                   | <input type="checkbox"/> <input type="checkbox"/> Hearing Impairment           |
| <input type="checkbox"/> <input type="checkbox"/> Any Operations                                       | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur                 |
| <input type="checkbox"/> <input type="checkbox"/> Asthma   | <input type="checkbox"/> <input type="checkbox"/> Head Injuries                |
| <input type="checkbox"/> <input type="checkbox"/> Attention Disorder                                   | <input type="checkbox"/> <input type="checkbox"/> Hemophilia                   |
| <input type="checkbox"/> <input type="checkbox"/> Autism   | <input type="checkbox"/> <input type="checkbox"/> Herpes                       |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion                                    | <input type="checkbox"/> <input type="checkbox"/> HIV / AIDS                   |
| <input type="checkbox"/> <input type="checkbox"/> Cancer   | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease               |
| <input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy                                       | <input type="checkbox"/> <input type="checkbox"/> Kidney / Liver Conditions    |
| <input type="checkbox"/> <input type="checkbox"/> Congenital Birth Defects                             | <input type="checkbox"/> <input type="checkbox"/> Rheumatic/Scarlet Fever      |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes   | <input type="checkbox"/> <input type="checkbox"/> Stomach Problems             |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness / Fainting                                 | <input type="checkbox"/> <input type="checkbox"/> Steroid Therapy/Chemotherapy |

Please discuss any serious medical conditions the child has had:  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list all drugs the child is currently taking: \_\_\_\_\_  
 \_\_\_\_\_

Please list all drugs the child is allergic to \_\_\_\_\_  
 \_\_\_\_\_

Child's Physician: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Is the child currently under the care of a physician?  Yes  No

### Health History Update

Date	Initials

For your convenience... Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

### 5. Mother's Information

Name \_\_\_\_\_  
Mother    Stepmother    Guardian    Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer \_\_\_\_\_  
Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
Home # (\_\_\_\_\_) \_\_\_\_\_  
Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_  
SS # \_\_\_\_\_ DL# \_\_\_\_\_

### 6. Father's Information

Name \_\_\_\_\_  
Father    Stepmother    Guardian    Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer \_\_\_\_\_  
Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
Home # (\_\_\_\_\_) \_\_\_\_\_  
Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_  
SS # \_\_\_\_\_ DL# \_\_\_\_\_

### 7. Person Responsible for Account

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Billing Address \_\_\_\_\_  
\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home # (\_\_\_\_\_) \_\_\_\_\_  
Work # (\_\_\_\_\_) \_\_\_\_\_  
Cellular # (\_\_\_\_\_) \_\_\_\_\_  
E-mail \_\_\_\_\_

### 8. Who is Accompanying the Child Today?

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Do you have legal custody of this child?     Yes     No

### 9. Primary Dental Insurance

Insurance Co. Name \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
\_\_\_\_\_  
Insurance Co. Phone # (\_\_\_\_\_) \_\_\_\_\_  
Group # (Plan, Local, or Policy #) \_\_\_\_\_  
Policy Owner's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Policy Owner's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Subscriber ID # \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Policy Owner's Employer \_\_\_\_\_

### 10. Secondary Dental Insurance

Insurance Co. Name \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
\_\_\_\_\_  
Insurance Co. Phone # (\_\_\_\_\_) \_\_\_\_\_  
Group # (Plan, Local, or Policy #) \_\_\_\_\_  
Policy Owner's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Policy Owner's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Subscriber ID # \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Policy Owner's Employer \_\_\_\_\_

**Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.**

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 my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_