Print Form

Dr. Stella's

Funtastic Dental And Orthodontics

Today's Date: _____

TELL US ABOUT YOUR CHILD

Child's Name: _____ Nickname: _____ ○ Male ○ Female
(LAST / FIRST / MI)

Birthdate: ____/____/____ Age: _____ School: _____ Grade: _____

Child's Home #: (_____) _____ SS#: _____

Child's Home Address: _____
(STREET / CITY / STATE / ZIP)

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: _____ Relation: _____

Do you have legal custody of this child? ○ Yes ○ No Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____ Last Visit Date: _____

Parent's Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

MOTHER OF CHILD

○ Step Mother ○ Guardian

Name: _____

Birthdate: _____/_____/_____

Wk #: _____ Hm #: _____

Employer: _____

SS#: _____ DL#: _____

FATHER OF CHILD

○ Step Father ○ Guardian

Name: _____

Birthdate: _____/_____/_____

Wk #: _____ Hm #: _____

Employer: _____

SS#: _____ DL#: _____

PERSON RESPONSIBLE FOR ACCOUNT

Billing:

Name: _____ Relation: _____ SS#: _____ DL#: _____
(LAST / FIRST / MI)

Billing Address: _____
(STREET / CITY / STATE / ZIP)

Home #: (_____) _____ Employer: _____ Work #: (_____) _____

Appointments:

Name: _____ Hm #: (_____) _____ Wk #: (_____) _____
(LAST / FIRST / MI)

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Group # (Plan, Local, or Policy #): _____

Address: _____

Phone #: (_____) _____

Policy Owner Name: _____

Relationship to Patient: _____

Orthodontic Coverage? ○ Yes ○ No Birthdate: ____/____/_____

SS#: _____ Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Group # (Plan, Local, or Policy #): _____

Address: _____

Phone #: (_____) _____

Policy Owner Name: _____

Relationship to Patient: _____

Orthodontic Coverage? ○ Yes ○ No Birthdate: ____/____/_____

SS#: _____ Employer: _____

WHY DID YOU BRING THE CHILD TO THE DENTIST TODAY?

Reason of Visit Today: _____

_____

Has the child ever had a serious/difficult problem associated with previous dental work? ○ Yes ○ No
Is the child's water fluoridated? ○ Yes ○ No
Is the child taking fluoridated supplements? ○ Yes ○ No
Has the child ever had any pain / tenderness in his/her jaw joint (TMJ/TMD)? ○ Yes ○ No
Does the child brush his/her teeth daily? ○ Yes ○ No
Does the child floss his/her teeth daily? ○ Yes ○ No

Child's Physician: _____ Phone: (____) _____ Last Visit: ____/____/_____
Is the child currently under the care of a physician? ○ Yes ○ No
Please describe the child's current physical health: ○ Good ○ Fair ○ Poor
Please list all drugs that the child is currently taking: _____

_____

Please list all drugs/materials that the child is allergic to: _____

_____

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Abnormal Bleeding	○ Yes ○ No	Congenital Heart Defect	○ Yes ○ No	Hemophilia	○ Yes ○ No
Allergies to Any Drugs	○ Yes ○ No	Convulsions / Epilepsy	○ Yes ○ No	Hepatitis	○ Yes ○ No
Any Hospital Stays	○ Yes ○ No	Diabetes	○ Yes ○ No	HIV+ / AIDS	○ Yes ○ No
Any Operations	○ Yes ○ No	Handicaps / Disabilities	○ Yes ○ No	Kidney / Liver Problems	○ Yes ○ No
Asthma	○ Yes ○ No	Hearing Impairment	○ Yes ○ No	Rheumatic / Scarlet Fever	○ Yes ○ No
Cancer	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Tuberculosis (TB)	○ Yes ○ No

Please discuss any serious medical problems that the child has had: _____

_____

_____

DOES/DID THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

Lip Sucking / Biting	○ Yes ○ No	Nail Biting	○ Yes ○ No
Nursing Bottle Habits	○ Yes ○ No	Thumb / Finger Sucking	○ Yes ○ No

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 that 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: _____/_____/_____

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.
Initials: _____ **Date:** _____
Doctor's Comments: _____

_____

_____

Medical History Update
1. Date: _____ Signature: _____
Comments: _____

_____

2. Date: _____ Signature: _____
Comments: _____