



**** Welcome ****

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on comprehensive care focusing on prevention and cosmetics. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Today's date: _____

TELL US ABOUT YOUR CHILD

Child's Name: _____ Nickname: _____
Child's Birth Date _____ Child's Age: _____ Male: Female:
School: _____ Grade: _____
Child's Home #: _____ SS#: _____
Child's Address _____ City _____ State _____ Zip: _____
Whom may we contact in case of emergency? Name: _____ Tel. #: _____
Address: _____ City: _____ State: _____ Zip: _____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____ Relation: _____
Do you have legal custody of this child? Yes: No:
Who may we thank for referring you? _____
Address: _____ Phone: _____
Other family members seen by us: _____
Previous/Present Dentist: _____ City/State: _____ Last Visit Date: _____
Parent's Marital Status: Single Married Widowed Divorced Separated

PARENTS' INFORMATION

Mother's Information _____ Stepmother _____ Guardian _____
Name: _____ Work #: _____ Home #: _____ Pager/Cell #: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ SS#: _____ DL#: _____
Address: _____ City: _____ State: _____ Zip: _____

Father's Information _____ Stepfather _____ Guardian _____
Name: _____ Work #: _____ Home #: _____ Pager/Cell#: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ SS#: _____ DL#: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail address: _____ (mother) _____ (father)

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name _____ Ins. Co. Phone #: _____
Insurance Co. Address: _____
Group #: (Plan, Local, or Policy #): _____
Insured's Name: _____ Relationship to patient: _____
Insured's Birthday: _____ Insured's SS#: _____
Insured's Employer: _____ Orthodontic Coverage? Yes No

Secondary Dental Insurance

Insurance Co. Name: _____ Ins. Co. Phone #: _____
Insurance Co. Address: _____
Group #: (Plan, Local, or Policy #): _____
Insured's Name: _____ Relationship to patient: _____
Insured's Birthday: _____ Insured's SS#: _____
Insured's Employer: _____ Orthodontic Coverage? yes no

Why did you bring your child to the dentist today? _____
 Has your child ever had a serious / difficult problem associated with previous dental work? _____
 If yes, describe _____
 Does your child drink bottled water? _____ tap water? _____ both tap and bottled water? _____
Is your child's water fluoridated? _____ yes _____ no _____ unsure
 Does your child drink filtered water? _____ yes _____ no If yes, is it by reverse osmosis? _____ yes _____ no
Is your child taking fluoridated supplements? _____ yes _____ no
 Is your child currently in pain? _____ yes _____ no If yes, describe _____
 For how long? _____ Any fever or swelling? _____ Has Advil, Tylenol, etc. helped? _____
 Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? _____ yes _____ no
 Does your child brush his/her teeth daily? _____ yes _____ no Is brushing supervised? _____ yes _____ no
 Does your child floss his/her teeth daily? _____ yes _____ no
 Does your child eat sticky/sugary foods? _____ yes _____ no If yes, how often? _____
Child's Physician: _____
Phone #: _____ **Date of last visit:** _____
 Is your child currently under the care of a physician? _____ yes _____ no
Please describe your child's current physical health: _____ good _____ fair _____ poor

Please list all drugs (prescription/non-prescription/vitamins/herbal supplements) that your child is currently taking _____

Is your child allergic to any of the following drugs or materials? (Please check all applicable)
 Aspirin Dental Anesthetics Latex Tetracycline
 Codeine Erythromycin Penicillin Other: _____
 Describe the allergic reaction: _____
 Please list any other drugs that your child is allergic to/ describe the reaction: _____

****My child has no known drug allergies or allergies to materials (if applicable) _____ yes****

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? (Please check all applicable)
 Allergies/Hay Fever Cancer Hearing Impairment Nervous Disorders
 Anemia Congenital Heart Defect Hepatitis Rheumatic Fever
 Asthma Diabetes Kidney Disease Sinus Problems
 Abnormal Bleeding/Hemophilia Disability Liver Disease/Jaundice Tuberculosis
 Heart Murmur Mental Disorders Other _____

****My child has no known medical problems/concerns (if applicable): _____ yes****
 Please discuss any serious medical problems that your child has had, including surgeries and hospitalizations: _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS? (Please check all applicable)
 Thumb/Finger Sucking Lip Sucking/Biting Nail Biting Nursing Bottle Habits (bottle at bedtime)

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 also 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.

For Office Use Only

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein:
 Initials _____ Date: _____

Comments: _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment of the insurance benefits otherwise payable to me directly to Joseph Renzi, Jr., D.D.S., Inc. I understand that I am financially responsible for any charges not covered by my insurance. I authorize release of any information necessary for filing of dental insurance claims.

 Signature of Father/Guardian (if insured) Date

 Signature of Mother/Guardian (if insured) Date