ELDORA
FAMILY DENTISTRY & ORTHODONTICS

WELCOME

We would like to welcome you and your child to Eldora Family Dentistry & Orthodontics. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: ______________________

Child's Name: ______________________

Nickname: ______________________ ☐ Male ☐ Female

Child's Birthdate: ____/____/____ Child's Age: __________

School: ______________________ Grade: __________

Child's Home #: ______________________ SS#: ______________________

E-mail Address: ______________________

Child's Home Address:

____

____

2 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 ☐ Widowed ☐ Partnered ☐ Married ☐ Divorced ☐ Seperated

3 ☐ Mother's Information ☐ Step Mother ☐ Guardian

Name: ______________________ Birthdate: ___/___/___

Email Address: ______________________

Hm #: ______________________ Cell #: ______________________

Employer: ______________________ Wk #: ______________________

SS #: ______________________ DL #: ______________________

☐ Father's Information ☐ Step Father ☐ Guardian

Name: ______________________ Birthdate: ___/___/___

Email Address: ______________________

Hm #: ______________________ Cell #: ______________________

Employer: ______________________ Wk #: ______________________

SS #: ______________________ DL #: ______________________

4 Person Responsible for Account

Name: ______________________ Relation: __________

Billing Address: ______________________

____

Hm #: ______________________ DL #: ______________________

Employer: ______________________

Wk #: ______________________ Ext: _____ SS #: ______________________

Who is responsible for making appointments:

Name: ______________________

Wk #: ______________________ Ext: _____ Hm #: ______________________

5 Primary Dental Insurance

Insurance Co. Name: ______________________

Insurance Co, Address: ______________________

Insurance Co. Ph # ______________________

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

Policy Owner's Name: ______________________

Relationship to Patient: ______________________

Policy Owner's Birthdate: ___/___/___ ID #: ______________________

Policy Owner's Employer: ______________________

Employer's Address: ______________________

Orthodontic Coverage? ☐ Yes ☐ No

Secondary Insurance

Insurance Co. Name: ______________________

Insurance Co, Address: ______________________

Insurance Co. Ph # ______________________

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

Policy Owner's Name: ______________________

Relationship to Patient: ______________________

Policy Owner's Birthdate: ___/___/___ ID #: ______________________

Policy Owner's Employer: ______________________

Employer's Address: ______________________

Orthodontic Coverage? ☐ Yes ☐ No

CONTINUED ON BACK

6 Why did you bring the child to the dentist today? ______________________

Has the child ever had a serious / difficult problem assicated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking flouridated supplements? ☐ Yes ☐ No

Has the child ever had any pain / tenderness is 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

Child's Physician: ______________________

Ph #: ______________ Date of Last Visit: __________

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

Please describe your child's current physical health:
☐ Good ☐ Fair ☐ Poor

Has your child ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Has your child ever taken Phen-Fen? ☐ Yes ☐ No

Please list all drugs that the child is currently taking: ______________________

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

Latex? ☐ Yes ☐ No Metals/Nickel? ☐ Yes ☐ No

Plastic? ☐ Yes ☐ No

7 Has the child ever had any of the following medical problems?

(Please circle "Y" for YES "N" for No)

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	ADD / ADHD	Y	N	Handicaps / Disabilities
Y	N	Allergies to any drugs	Y	N	Hearing Impairment
Y	N	Any Hospital Stays	Y	N	Heart Murmur
Y	N	Any Operations	Y	N	Hemophilia
Y	N	Articifical Bones / Joints / Valves	Y	N	Hepatitis
			Y	N	HIV+ / AIDS
Y	N	Asthma	Y	N	Kidney / Liver Problems
Y	N	Cancer	Y	N	Rheumatic / Scarlet Fever
Y	N	Congenital Heart Defect	Y	N	Sickle Cell Disease / Traits
Y	N	Convulsions / Epilepsy	Y	N	Tuberculosis (TB)

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

8 Does / did the child have any of the following habits? (Please circle "Y" for YES "N" for No)

Y	N	Lip Sucking / Biting	Y	N	Nursing Bottle Habits
Y	N	Nail Biting	Y	N	Thumb / Finger Sucking

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated my OSHA, the CDC & the ADA.

Neighbor or Relative not living with you:

Name: ______________ Ph #: __________

Address: ______________________

CITY STATE ZIP

9

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 reponsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff of Eldora Family Dentistry & Orthodontics to perform the necessary dental services my child may need.

Signature ______________ Date __________

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

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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: ______________________