

Dear Parent,

We are excited to welcome you to our dental practice. We love working with children because we believe that the prevention of dental disease and the establishment of good oral hygiene habits are essential in the development of a healthy smile. Dr. Franz and her staff of highly trained professionals are dedicated to providing our patients with the finest in quality dentistry. We are sensitive to the physical and psychological needs of our young patients and try to make their visits as comfortable as possible. Your role as a parent is essential in preparing your child for their dental visit. Speak with them about coming to the dentist as a positive experience and refrain from using words around your child that may cause unnecessary fear, such as hurt, needle, pull or drill, shot or pain.

We invite you to stay with your child during their initial examination. We will examine your child's teeth and determine if x-rays and /or cleaning are indicated. If any future treatment is necessary such as fillings or sealants this will occur at a follow-up visit. You are welcome to accompany your child to their cleaning and "check up" appointment. This allows you to meet the doctor and clinical staff, ask questions and learn about oral hygiene techniques. However, if dental treatment is necessary, we request that you allow your child to enter the treatment area by themselves.

We can usually establish a closer rapport with your child when you are not present. This also allows your child to establish an uninterrupted relationship with the doctor and staff. Our purpose is to gain your child's confidence and overcome apprehension.

Please remember to fill out the downloadable Health History form and be aware that a parent or legal guardian must accompany your child to their dental visits.

If you are referred by another dentist, please have your child's dental records, including current x-rays to our office prior to the appointment. Digital x-rays may not be diagnostic and may have to be retaken at our office.

Should you need to change your appointment time, we ask that you please give us up to 48 hours notice so that we may offer this time to another child.

We require payment at the time services are rendered. You may pay with cash, check, Visa or Mastercard.

As a courtesy we can file your insurance for you if we are given the necessary information. If you want your insurance to be filed on your behalf, please read the dental insurance section on our site under Office Policies very carefully

We are proud to be your child's Dental Home and look forward to your visit!

# Welcome



## Health History Form

Today's Date: \_\_\_\_\_

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

### 1. Tell Us About Your Child

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

Goes by: \_\_\_\_\_  Male  Female

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

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

School \_\_\_\_\_ Grade \_\_\_\_\_

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

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

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

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

Email Address: \_\_\_\_\_

### 2. Who may we thank for referring you to our office?

\_\_\_\_\_

### 3. Mother's Information

Name \_\_\_\_\_

Mother Stepmother Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

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

### 4. Father's Information

Name \_\_\_\_\_

Father Stepmother Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

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

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

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

### 6. Person Responsible for Account

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Billing Address \_\_\_\_\_

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

Home # (\_\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_

Cellular # (\_\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_

### 7. 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or guardian \_\_\_\_\_

Date \_\_\_\_\_

**9. Dental History**

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

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

Previous Dentist's Name \_\_\_\_\_

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?

Y  N Lip Sucking / Biting       Y  N Nail Biting

Y  N Nursing / Bottle Habits       Y  N 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**

**10. Health History**

Has the child ever had any of the following conditions?

Y  N Abnormal Bleeding       Y  N Disabilities/Special Needs

Y  N Allergies to any Drugs       Y  N Hearing Impairment

Y  N Any Hospital Stays       Y  N Heart Disease/Murmur

Y  N Any Operations       Y  N Hemophilia/Blood Disorders

Y  N Asthma       Y  N Hepatitis

Y  N Cancer       Y  N HIV + / AIDS

Y  N Congenital Birth Defects       Y  N Kidney/Liver Conditions

Y  N Convulsions/Epilepsy       Y  N Rheumatic/Scarlet Fever

Y  N Pregnancy       Y  N Allergies to Latex Product

Y  N Tuberculosis       Y  N Diabetes

Y  N ADD/ADHD       Y  N Autism

Please discuss any serious medical conditions the child has had

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

Please list all allergies \_\_\_\_\_

\_\_\_\_\_

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

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

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

Please describe the child's current physical health...

**Good**      **Fair**      **Poor**

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

**11.** 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

***For Office Use Only***

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_