WELCOME TO LEHIGH DENTAL

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 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: _____
(Last) (First) (Middle)

Nickname: _____ ☐ Male ☐ Female

Child's Birth date: _____ / _____ / _____ Child's Age: _____ SS #: _____

School: _____ Grade: _____

Child's Home Ph: (_____) _____ Email 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: _____

Parents Marital Status:
☐ Single ☐ Married ☐ Married ☐ Divorced ☐ Partnered ☐ Separated

3. PARENTAL INFORMATION

Mother's Information: ☐ Step Mother ☐ Guardian

Name: _____ Birth date: _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

Employer: _____ Work Ph: (_____) _____

SS #: _____ DL #: _____

Father's Information: ☐ Step Father ☐ Guardian

Name: _____ Birth date: _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

Employer: _____ Work Ph: (_____) _____

SS #: _____ DL #: _____

2. PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____

_____

Home Ph: (_____) _____ DL #: _____

Employer: _____

Work Ph: (_____) _____ Ext: _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Work Ph: (_____) _____ Ext: _____ Home Ph: (_____) _____

5. INSURANCE

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 Owners Birth Date: _____ / _____ / _____ ID#: _____

Policy Owner's Employer: _____

Employer's Address: _____

_____

Orthodontic Coverage? ☐ Yes ☐ No

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 Owners Birth Date: _____ / _____ / _____ ID#: _____

Policy Owner's Employer: _____

Employer's Address: _____

_____

Orthodontic Coverage? ☐ Yes ☐ No

6. DENTAL HISTORY

Why did you bring the child to the dentist 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
Floss his / her teeth daily?	☐ Yes	☐ No

Child's Physician: _____

Phone #: (_____) _____ Date of 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

Has your child ever taken Phen-Fen? (also known as Redux or Pondimin)	☐ Yes	☐ No

If so, when? _____

Please list any 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?

☐ Yes ☐ No Abnormal Bleeding
☐ Yes ☐ No ADD/ADHD
☐ Yes ☐ No Allergies to any drugs
☐ Yes ☐ No Any Hospital Stays
☐ Yes ☐ No Any Operations
☐ Yes ☐ No Artificial Bones/Joints/Valves
☐ Yes ☐ No Asthma
☐ Yes ☐ No Cancer
☐ Yes ☐ No Congenital Heart Defect
☐ Yes ☐ No Convulsions / Epilepsy
☐ Yes ☐ No Tuberculosis (TB)
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Handicaps / Disabilities
☐ Yes ☐ No Hearing Impairment
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No HIV+ / AIDS
☐ Yes ☐ No Kidney / Liver Problems
☐ Yes ☐ No Rheumatic / Scarlet Fever
☐ Yes ☐ No Sickle Cell Disease / Traits

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

_____

_____

_____

8. DOES/DID THE CHILD EVER HAVE ANY OF THE FOLLOWING HABITS?

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

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

Neighbor or Relative not living with you:

Name: _____ Phone: (_____) _____

Address: _____

_____

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) (Date)

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http://www.lehighdental.net

OFFICE USE ONLY – OFFICE USE ONLY – OFFICE USE ONLY – OFFICE USE ONLY

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

Initials: _____ Date: _____

Doctor's Comments

_____

_____

_____

_____

_____

MEDICAL HISTORY UPDATE

1. Date: _____ Signature: _____

Comments: _____

_____

2. Date: _____ Signature: _____

Comments: _____

_____