BELMONT Dental Care
FOR YOUR PERFECT SMILE!

Welcome

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

Tell Us About Your Child

Today's Date _____

Child's Name: _____
Last First MI

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

Nickname: _____ ❑ Male ❑ Female

School: _____ Grade: _____

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

Child's Home Address: _____
Apt. / Condo #

_____
City State Zip

Cell Phone: _____

Who is Accompanying The Child Today?

Name: _____

Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Is the child adopted? ❑ Yes ❑ No

Is the child in a foster home? ❑ Yes ❑ No

Whom may we thank for referring him/her? _____

Other siblings seen by us: _____

Parent's Marital Status: ❑ Single ❑ Widowed ❑ Life Partnership ❑ Married ❑ Divorced ❑ Separated

Who is Responsible for Making Appointments!

Name: _____

Relation: _____

Work Phone: (___) _____ Pager: (___) _____

Home Phone: (___) _____ Cell Phone: (___) _____

Email Address: _____

Preferred Contact? _____

Parent's Information

Mother ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: _____

Work Phone: (___) _____ Home Phone: (___) _____

Cell Phone: (___) _____ Email: _____

Employer: _____ Occupation: _____

Length of Employment: _____ SS#: _____

Father ❑ Step Father ❑ Guardian

Name: _____ Birthdate: _____

Work Phone: (___) _____ Home Phone: (___) _____

Cell Phone: (___) _____ Email: _____

Employer: _____ Occupation: _____

Length of Employment: _____ SS#: _____

Person Responsible for Account

Name: _____ Relationship: _____

Billing Address: _____

_____
City State Zip

Work Phone: (___) _____ Home Phone: (___) _____

Employer: _____

Occupation: _____

Driver's License #: _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover.

For your convenience, we offer the following payment options.

Please check the option which you prefer:

❑ Cash

❑ Personal Check

❑ Credit Card

❑ Visa ❑ MasterCard ❑ Discover ❑ American Express

_____
Signature Date

Primary Insurance

Dental Coverage? ❑ Yes ❑ No

Insurance Company Name: _____

Insurance Company Address: _____

_____
City State Zip

Insurance Co. Phone: (___) _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ SS#: _____

Policy Owner's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Insurance

Dental Coverage? ❑ Yes ❑ No

Insurance Company Name: _____

Insurance Company Address: _____

_____
City State Zip

Insurance Co. Phone: (___) _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ SS#: _____

Policy Owner's Employer: _____

Employer's Address: _____

_____
City State Zip

Confidential Health History

BELMONT Dental Care
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Your child's overall health, as well as, any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.
Thank You.

What is the primary reason for today's visit?

_____

_____

Your child's current health: ❑ Good ❑ Fair ❑ Poor

Date of child's last dental visit: _____

Previous Dentist: _____ Phone #: (___) _____

Has your child experienced problems associated with previous dental work? ❑ Yes ❑ No

Is your child's water fluoridated? ❑ Yes ❑ No

Does your child take fluoride supplements? ❑ Yes ❑ No

Do you like your child's smile? ❑ Yes ❑ No

If not, why? _____

Does your child have bleeding gums? ❑ Yes ❑ No

How often does your child brush? _____

Type of toothbrush: ❑ Manual ❑ Electric

What brand? _____

Type of bristles on toothbrush? ❑ Hard ❑ Medium ❑ Soft

How long does your child use a toothbrush before replacing it? _____

How often does your child floss? _____

Are your child's teeth sensitive to heat, cold, or anything else? _____

Has your child lost any teeth? ❑ Yes ❑ No If yes why: _____

_____

Have there been any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No

List any musical instruments played: _____

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has your child been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Does your child participate in any sports? ❑ Yes ❑ No

Which ones? _____

Does he/she use a mouth guard? ❑ Yes ❑ No

OFFICE USE ONLY

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

Doctor's Comments: _____

_____

_____

_____

_____

_____

_____

FORM 002010 R/12/10 ITEM 8101

Child's Physician: _____

Phone#: (___) _____ Date of Last Visit: _____

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

Describe your child's current physical health: ❑ Good ❑ Fair ❑ Poor

Please list all drugs that your child is currently taking _____

_____

Please list all drugs that cause your child allergic reactions: _____

_____

Has you child experienced the following medical problems?

❑ Yes ❑ No Abnormal Bleeding		❑ Yes ❑ No Hemophilia	
❑ Yes ❑ No AIDS/HIV+		❑ Yes ❑ No Hepatitis	
❑ Yes ❑ No Allergies		❑ Yes ❑ No High Blood Pressure	
❑ Yes ❑ No Anemia		❑ Yes ❑ No Hives	
❑ Yes ❑ No Any Hospital Stays		❑ Yes ❑ No Immunizations Current	
❑ Yes ❑ No Any Operations		❑ Yes ❑ No Kidney Disorder	
❑ Yes ❑ No Asthma		❑ Yes ❑ No Liver Disorder	
❑ Yes ❑ No Cancer		❑ Yes ❑ No Low Blood Pressure	
❑ Yes ❑ No Chicken Pox		❑ Yes ❑ No Measles	
❑ Yes ❑ No Congenital Heart Disease		❑ Yes ❑ No Mononucleosis	
❑ Yes ❑ No Diabetes		❑ Yes ❑ No Rheumatic Fever	
❑ Yes ❑ No Epilepsy/Seizures		❑ Yes ❑ No Scarlet Fever	
❑ Yes ❑ No Handicaps/Disabilities		❑ Yes ❑ No Skin Rash	
❑ Yes ❑ No Heart Murmur		❑ Yes ❑ No Tuberculosis (TB)	

Female Patients Only:

Is she taking birth control pills? ❑ Yes ❑ No

Is she pregnant? ❑ Unsure ❑ Yes ❑ No

Is she breast feeding? ❑ Yes ❑ No

Does/Did your child have any of the following habits?

❑ Yes ❑ No Lip Sucking/Biting		❑ Yes ❑ No Used a Pacifier?	
❑ Yes ❑ No Nail Biting		❑ Yes ❑ No Thumb/Finger Sucking	
❑ Yes ❑ No Chewing on Hard Objects (pencils, ice, etc.)		❑ Yes ❑ No Tongue/Cheek Biting	
		❑ Yes ❑ No Speech Problems	
❑ Yes ❑ No Mouth Breather		❑ Yes ❑ No Tongue Thrusting	
❑ Yes ❑ No Clenching/Grinding Teeth			

Please discuss any serious medical problems the child experiences/had:

_____

_____

Anything you would like to discuss with the doctor in private? ❑ Yes ❑ No

_____

_____

I affirm that the information I have given is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental 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.

RESET PRINT

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