Welcome!

Tell Us About Your Child

Today's Date:_____ Child's Home Phone #:_____ Social Security #:_____

Child's Name:_____ Child's Birthdate:_____ Child's Age:_____
Last First MI

Nickname:_____ ☐ M ☐ F School:_____

Child's Home Address:_____
Street City State Zip

Email Address:_____ Whom may we thank for referring you?_____

Best way to confirm appointments: ☐ Email ☐ Cell ☐ Home ☐ Work ☐ Text

Parent's Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single ☐ Partnered

MOTHER Name:_____ Birthday:_____

Home Phone #:_____ Work Phone #:_____

SS#:_____ Cell Phone #:_____

Address:_____
Street City State Zip

Employer:_____ Length of Employment:_____

FATHER Name:_____ Birthday:_____

Home Phone #:_____ Work Phone #:_____

SS#:_____ Cell Phone #:_____

Address:_____
Street City State Zip

Employer:_____ Length of Employment:_____

Insurance Information

PRIMARY DENTAL INSURANCE

Insured's Name:_____ Relationship to Patient:_____

Insured's Birthdate:_____ Insured's ID/SS#:_____

Insured's Employer:_____

Insurance Co. Name:_____ Phone #:_____ Group#:_____

SECONDARY DENTAL INSURANCE

Insured's Name:_____ Relationship to Patient:_____

Insured's Birthdate:_____ Insured's ID/SS#:_____

Insured's Employer:_____

Insurance Co. Name:_____ Phone #:_____ Group#:_____

Insurance Information

Is the child currently in pain? ☐ **Yes** ☐ **No** **What is the primary reason for today's visit?** _____

Has the child experienced problems with previous dental work? ☐ Y ☐ N

Is Fluoride taken is any form? ☐ Y ☐ N Any injuries to mouth, teeth, head? ☐ Y ☐ N

Does the child brush his/her teeth daily? ☐ Y ☐ N Floss his/her teeth daily? ☐ Y ☐ N

☐ Previous ☐ Present Dentist: _____ Date of Last Visit: _____

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least? _____

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

☐Y ☐N Lip Sucking/Biting ☐Y ☐N Clenching/Grinding Teeth ☐Y ☐N Tongue/Cheek Biting ☐Y ☐N Mouth Breather
☐Y ☐N Nail Biting ☐Y ☐N Thumb/ Finger Sucking ☐Y ☐N Used/Uses Pacifier ☐Y ☐N Speech Therapy
☐Y ☐N Chewing on Objects ☐Y ☐N Nursing/Bottle Habits ☐Y ☐N Tongue Thrust

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Child's Physician: _____ Phone #: _____ Date of last visit: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? ☐ Yes ☐ No Please explain: _____

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor Are immunizations current? ☐ Yes ☐ No

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

Preferred Pharmacy: _____

Besides the following, please list all drugs and/or things that cause the child allergic (itching, swelling, hives) reactions:

☐Y ☐N Latex ☐Y ☐N Metals/Nickel ☐Y ☐N Plastic/Acrylic ☐Y ☐N Penicillin ☐Y ☐N Codeine ☐Y ☐N Sulfa Drugs

If others, please explain: _____

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Has the child had/experienced any of the following:

☐Y ☐N Abnormal Bleeding	☐Y ☐N Chicken Pox/Shingles	☐Y ☐N Hepatitis	☐Y ☐N Rheumatic Fever*
☐Y ☐N AIDS/HIV+	☐Y ☐N Congenital Heart Defect	☐Y ☐N High Blood Pressure	☐Y ☐N Scarlet Fever
☐Y ☐N Allergies	☐Y ☐N Convulsions	☐Y ☐N Hives	☐Y ☐N Sickle Cell Anemia
☐Y ☐N Anemia	☐Y ☐N Diabetes Type I or II	☐Y ☐N Kidney Problems	☐Y ☐N Sinus Problems
☐Y ☐N Any hospital stay/operations	☐Y ☐N Epilepsy	☐Y ☐N Liver Problems	☐Y ☐N Skin Rash
☐Y ☐N Artificial Implants*	☐Y ☐N Handicaps/Disabilities	☐Y ☐N Low Blood Pressure	☐Y ☐N Thyroid Disease
☐Y ☐N Asthma	☐Y ☐N Hearing Impairment	☐Y ☐N Lupus	☐Y ☐N Tonsillitis
☐Y ☐N Bladder Problems	☐Y ☐N Heart Murmur*	☐Y ☐N Measles	☐Y ☐N Tuberculosis (TB)
☐Y ☐N Blood Transfusions	☐Y ☐N Heart Problems*	☐Y ☐N Mitral Valve Prolapse*	☐Y ☐N ADD/ADHD
☐Y ☐N Cancer/Chemotherapy	☐Y ☐N Hemophilia	☐Y ☐N Mononucleosis	☐Y ☐N Special Challenges

* By checking these health conditions, be aware that you may need dental antibiotic premedication._____ (initial)

If not, release from a treating physician is necessary. _____ (initial)

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

_____

HIPAA (PATIENT)

May we have permission to leave a message at your: Home # ☐Y ☐N Work # ☐Y ☐N Cell # ☐Y ☐N

Best number to use: ☐ Home ☐ Work ☐ Cell Phone ☐ Other: _____

Discuss your treatment /account with anyone? ☐Y ☐N If yes, Name/Relationship/Phone: _____

☐ I have received the Lighthouse Dental Privacy Notice.

☐ I agree to email/text communication with Lighthouse Dental. E-mail Address: _____
(Information will not be sold or shared with entities outside of Lighthouse Dental)

I affirm that the information I have given is correct to the best of my knowledge, and that 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 services that my child may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature _____ Date _____