About Your Child

NAME		
NICKNAME		
BIRTHDATE	MALE FEMAI	E
ss#	AGE	-/
SPECIAL INTERESTS, SPOR	RTS OR HOBBIES:	
HOME ADDRESS		
HOME PHONE		
REFERRED BY		\dashv
	9	
	1000	

YOUR NAME BIRTHDATE SS# RELATIONSHIP TO CHILD HOME PHONE HOME ADDRESS EMPLOYER OCCUPATION

CELL PHONE

EMAIL

WORK PHONE

About You

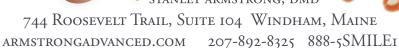
We would like to welcome you and your child to Armstrong Advanced Dental Concepts. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Insurance

INSURANCE COMPANY					
GROUP #	INSURED'S ID #				
EMPLOYER NAME					
INSURED'S NAME					
INSURED'S DATE OF BIRTH					
INSURED'S RELATIONSHIP TO PATIENT					
INSURED'S SSN	PATIENT'S SSN				
Secondary Insurance					

INSURED'S SSN	PATIENT'S SSN	
Secondary	Insurance	
INSURANCE COMPANY		
GROUP #	INSURED'S ID #	
EMPLOYER NAME		
INSURED'S NAME		
INSURED'S DATE OF BIRTH	I	
INSURED'S RELATIONSHIP	TO PATIENT	
INSURED'S SSN	PATIENT'S SSN	





Dental/Medical History IF YES, THE APPROXIMATE DATE OF LAST VISIT: ARE THERE ANY DENTAL PROBLEMS THAT YOU ARE AWARE OF AT PRESENT? IF YES, PLEASE EXPLAIN:

S	YOUR	CHILD	BEEN	ТО	THE	DENTIST	BEFORE?	Yes	☐ No

Yes No

DOES YOUR CHILD BRUSH HIS/HER TEETH DAILY? Yes No

RATE YOUR CHILD'S ORAL HEALTH: Good Fair Poor

CHILD'S PHYSICIAN:

PHYSICIAN PHONE NUMBER: _

APPROXIMATE DATE OF LAST VISIT: _

RATE YOUR CHILD'S MEDICAL HEALTH: Good Fair Poor

IS YOUR CHILD ALLERGIC TO ANY DRUGS OR

Yes No OTHER THINGS?

IF YES, PLEASE LIST: __ IS YOUR CHILD TAKING ANY PRESCRIPTION Yes No

DRUGS? IF YES, PLEASE LIST: ___

DOES YOUR CHILD REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT?

Yes No

Medical Conditions

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING CONDITIONS?

- N Any Hospital Stays
- Any Operations
- Bleeding Problems of Any Kind
- Cancer
- Convulsions/Epilepsy
- Diabetes
- N Hearing Impairment
- N Heart Murmur
- N Heart Problems of Any Kind
- N Hemophilia
- N HIV+/AIDS
- N Hyperactive
- Rheumatic/Scarlet Fever

ARE THERE ANY OTHER MEDICAL CONDITIONS OR PROBLEMS RELATING TO YOUR CHILD?

Yes No

IF YES, PLEASE LIST:

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.

Nutrition & Supplements

LIST ANY SUPPLEMENTS/VITAMINS THAT YOUR CHILD TAKES:

CIRCLE FOODS PART OF YOUR CHILD'S DIET:

MILK SODA CANDY SPORTS-DRINKS

DOES YOUR CHILD:

Yes No TAKE FLUORIDE TABLETS

Yes No DRINK FLUORIDATED WATER

USE TOOTHPASTE WITH FLUORIDE

Yes No

Emergency Contact



NAME

RELATIONSHIP

HOME PHONE

WORK PHONE

CELL PHONE

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. THE PARENT OR GUARDIAN WHO ACCOMPANIES THE CHILD IS RESPONSIBLE FOR PAYMENT AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

SIGNATURE

DATE

Thank you for filling out this form completely. It will enable us to give your child the best dental Care possible. If you or your child have any questions, please feel free to ask us at any time.