

# Welcome to Atkinson Dental Clinic

Here at Atkinson Dental Clinic, our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care and we strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.



## Information About the Child

Today's Date:	
Child's Name:	Nickname:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Child's Birth Date: / /
Child's SS#:	
Child's Home Address:	
City:	State: Zip:
Home Phone:	
Name of Person With Child Today:	
Relationship to the Child:	
Do you have legal custody of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the child in a foster home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other siblings who are our patients:	
Previous Dentist:	
Date of Last Dental Visit:	
Parents' Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered	



## Parents' Information

<b>Mother</b> <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Stepmother <input type="checkbox"/> Is Deceased	
Name:	Birth Date: / /
Home Address:	
City:	State: Zip:
Work Phone:	
SS#:	DL#:
<b>Father</b> <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Stepfather <input type="checkbox"/> Is Deceased	
Name:	Birth Date: / /
Home Address:	
City:	State: Zip:
Work Phone:	
SS#:	DL#:



## Person Responsible for Account

Name:	
Billing Address:	
City:	State: Zip:
Home Ph#:	Work Ph#:
Employer:	
SS#:	DL#:
<b>Who is responsible for making appointments?</b>	
Name:	
Home Ph#:	Work Ph#:



## Dental Insurance Information

<b>PRIMARY INSURANCE</b>	
Insurance Company:	
Claims Address:	
City:	State: Zip:
Ins. Co. Phone#:	
Group#:	
Name of Insured:	
Relationship to Patient:	
SS# of Insured:	
Birth Date of Insured: / /	
Name of Insured's Employer:	
Employer's Address:	
City:	State: Zip:
<b>SECONDARY INSURANCE</b>	
Insurance Company:	
Claims Address:	
City:	State: Zip:
Ins. Co. Phone#:	
Group#:	
Name of Insured:	
Relationship to Patient:	
SS# of Insured:	
Birth Date of Insured: / /	
Name of Insured's Employer:	
Employer's Address:	
City:	State: Zip:

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## Child's Medical History

Child's Medical Doctor: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Last Visit to Medical Doctor: \_\_\_\_\_

Child's Current Health Status:  Good  Fair  Poor

Please list any other prescription drugs, over the counter drugs, or herbal/natural supplements the child is taking:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the child have a medical condition that requires him/her to take antibiotics before receiving dental treatment?  Yes  No

Has the child ever taken Phen-Fen, Redux or Pondimin?  Yes  No If Yes, when? \_\_\_\_\_

Are the child's immunizations current?  Yes  No

Has the child ever been diagnosed with or treated for any of the following conditions? (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Abnormal Bleeding              | <input type="checkbox"/> Heart Murmur             |
| <input type="checkbox"/> ADD/ADHD                       | <input type="checkbox"/> Hemophilia               |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Hepatitis                |
| <input type="checkbox"/> Artificial Bones/Joints/Valves | <input type="checkbox"/> Hives/Allergies          |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> HIV+ / AIDS              |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> Kidney/Liver Problems    |
| <input type="checkbox"/> Chicken Pox                    | <input type="checkbox"/> Measles                  |
| <input type="checkbox"/> Congenital Heart Defect        | <input type="checkbox"/> Mononucleosis            |
| <input type="checkbox"/> Diabetes (takes insulin)       | <input type="checkbox"/> Rheumatic/Scarlet Fever  |
| <input type="checkbox"/> Diabetes (takes oral meds)     | <input type="checkbox"/> Seizures (Non-Epileptic) |
| <input type="checkbox"/> Epilepsy                       | <input type="checkbox"/> Sickle Cell Disease      |
| <input type="checkbox"/> Exposed to HIV but neg.        | <input type="checkbox"/> Skin Rash                |
| <input type="checkbox"/> Hearing Impairment             | <input type="checkbox"/> Tuberculosis             |

Please list any other serious medical conditions or operations the child has or has had in the past: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the child allergic to any of the following? (Check all that apply)

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Penicillin   | <input type="checkbox"/> Tetracycline       |
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Latex              |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Codeine            |
| <input type="checkbox"/> Sulfa Drugs  | <input type="checkbox"/> Sedatives          |
| <input type="checkbox"/> Keflex       | <input type="checkbox"/> Nitrous Oxide      |
| <input type="checkbox"/> Metals       | <input type="checkbox"/> Dental Anesthetics |

Other allergies not listed above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## Child's Dental History

Why did you bring the child to the dentist today?  
\_\_\_\_\_

Has the child ever had a problem associated with previous dental work?  Yes  No

Is there fluoride in the child's water?  Yes  No

Does the child use a fluoride rinse?  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

Was the child breast-fed?  Yes  No

Does the child floss his/her teeth daily?  Yes  No

Does/did the child have any of the following habits:

Lip Sucking / Biting  Yes  No

Thumb / Finger Sucking  Yes  No

Nail Biting  Yes  No



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

I affirm that the information I have given on this form is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in this child's medical status. I authorize my insurance benefits be paid directly to Atkinson Dental Clinic and I understand that I am responsible for the payment of deductibles, co-payments, and any balances not covered by my insurance. I also authorize Atkinson Dental Clinic to release any information required to process the child's claims. I understand that payment is due at the time of service.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date