Cypress Orthodontic and Pediatric Dentistry

Welcome

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 preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell Us About Your Child

Today's date ______________________

Name ______________________
Last First MI

Preferred Name ______________ ❑ Male ❑ Female

Child's Birth Date ____/____/____ Child's Age ______

School ______________________ Grade______

Child's Home # ______________________

Child's Home Address

______________________ Apt/Condo # ______

____
City State Zip

Special Interests, Sports or Hobbies ______________________

____

Who is Accompanying the Child Today?

Name ______________________

Relationship ______________________

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

Is your child adopted? ❑ Yes ❑ No

How did you hear about our office? ______________________

Other family member(s) seen by us ______________________

Parent's Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Emergency Contact Information

In the event of an emergency, who should we contact (other than a parent)?

Name ______________________
Last First MI

Work # ______________________ Ext______

Home # ______________________

Mother's Information ❑ Step-Mother ❑ Guardian ❑

Name ______________________

Work # ______________________ Ext______

Home # ______________________

Employer ______________________

Cell # ______________________

Email ______________________

SS# ______________ DOB ______________

Father's Information ❑ Step-Father ❑ Guardian ❑

Name ______________________

Work # ______________________ Ext______

Home # ______________________

Employer ______________________

Cell # ______________________

Email ______________________

SS# ______________ DOB ______________

Dental Insurance

Insurance Co. Name ______________________

Insurance Co. Address ______________________

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Insurance Co. Phone ______________________

Group # (Plan, Local or Policy #) ______________________

Insured's Name ______________________

Relationship to Patient ______________________

Insured's Birth Date ______________________

SS# ______________ ID# ______________

Insured's Employer ______________________

Orthodontic Coverage? ❑ Yes ❑ No

Insured's Address ______________________

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Insured's Work # ______________________

Insured's Home # ______________________

Reason for today's visit ____________________

Please circle one.

- Has the child ever had a bad experience with dental work? **Yes** **No**
- Is the Child **Advanced** **Average** **Delayed** in social development?
- How would you describe the child's personality/temperament? Circle all that apply

  Cooperative **Uncooperative** **Sensitive** **Apprehensive** **Well-adjusted** **Aggressive** **Shy**
- Previous Dentists' name and phone number ____________________
- Last date seen ____________________ Last X-Rays taken ____________________
- Is your child's drinking fluoridated water? **Yes** **No**
- How many times a day are your child's teeth brushed? ____________________
- Is the child currently using the bottle **Yes** **No** How often? ____________________
- Current dental habits. Please circle if applicable. **Thumb/finger Sucking** **Use Pacifier** **Lip/Cheek Biting** **Nail Biting**
- Previous or current TMJ (jaw) pain, tenderness or popping? ____________________
- Does your child have or ever had recurring headaches **Yes** **No**
- Does your child have allergies to: **Anesthetics, local and general** **Latex** **Sedative Agent** **Drugs or medication** **Food** **Dyes** **Metal** **Acrylic** ____________________
- Has the child ever had any of the following medical problems? Please check (✓) all that applies:

__Apnea/snoring	__Convulsions/Seizures	__Hearing Impairments	__Mouth breathing
__Asthma	__ Diabetes	__Heart murmur	__Mumps
__ADHD/ADD	__Dizziness	__Hemophilia	__Prematurity
__Autism	__Growth problems	__Hepatitis	__Rheumatic fever
__Bruising easily	__Eating disorders	__HIV/AIDS	__Rubella
__ Blood Transfusion	__Endocrine System	__Learning disabilities	__Sickle cell disease/trait
__Cancer/tumors	__Excessive bleeding	__Liver or Kidney disorders	__Sight impairments
__Cerebral palsy	__Frequent infections	__Lung, respiratory problems	__Speech impairments
__Cleft lip/palate	__ Physical Disabilities	__Measles	__Tuberculosis
__ Heart Defects	__Gastrointestinal problems	__Mental retardation	__Varicella (Chicken Pox)
__Congenital anomalies	__Headaches/migraines	__Mononucleosis	

- Does your child have a heart murmur or condition that requires Antibiotic coverage for dental work? **Yes** **No**
- Please list any serious medical problem that the child has had ____________________

  ____
- Has your child ever been hospitalized: **Yes** **No** When and for what reason? ____________________

  ____
- Does your child have any emotional or school problems **Yes** **No** Explain ____________________
- Please list all the drug the child is currently taking ____________________

  Frequency ____________________ Dose ____________________
- Has the child has any recent infection of bacterial or viral origin? **Yes** **No**
- Is your child currently under the care of a physician **Yes** **No**

Child's Physician ____________________ Phone ____________________ Date last seen ____________________

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 also authorize the dental staff to perform the necessary services that 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.
I agree to pay any additional charges related to the costs of collection (including, but not limited to, collection agency fees, reasonable attorney fees and court costs) in the event that I would fail to pay my bill. If you have any questions, please feel free to ask us at any time.

Signature of parent or Legal guardian ____________________ Date ____________________

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

I verbally reviewed the medical /dental information above with the parent/legal guardian and patient named herein. Initials__________ Date___________