



Niloofer M Hubrich DMD, PC
General Dentistry for Children

Tell Us About Your Child

First Name: _____
Middle Name: _____
Last Name: _____
Birthdate: _____ Age: ____
Nickname: _____
Gender: male female
School: _____ Grade: _____
Hobbies: _____
Phone: _____
Street: _____
City: _____ State: _____ Zip: _____

General Information

Who is accompanying the child today?
Name: _____
Relation: _____
Does this person have legal custody of this child? Yes No
Whom may we thank for referring you? _____
Other siblings: _____
Previous/Present Dentist: _____
Last Visit Date: _____
Dentist's Phone #: _____

Relative or Friend not living with you

Name: _____
Phone: _____
Address: _____
City: _____ State: ____ Zip: _____

Parent's Information

Person Responsible for Account: _____
Parent's Marital Status: married single divorced widowed

Father, Step Father or Guardian

Name: _____ Birthdate: _____
Address: (if different than child's) _____
Home #: _____
Social Security #: _____ Driver's License #: _____
Work #: _____ Ext: _____ Cell/Other #: _____
Email: _____
Employer: _____

Employer's
Address: _____
City: _____ State: ____ Zip: _____

If you have Dental Insurance coverage for the Child, please fill out below:

Insurance Co.
Name: _____
Insurance Address: _____
City: _____ State: ____ Zip: _____
Insurance Phone: _____
Group # (Plan, Local, or Policy #): _____

Mother, Step Mother or Guardian

Name: _____ Birthdate: _____
Address: (if different than child's) _____
Home #: _____
Social Security #: _____ Driver's License #: _____
Work #: _____ Ext: ____ Cell/Other #: _____
Email: _____
Employer: _____
Employer's
Address: _____
City: _____ State: ____ Zip: _____

If you have Dental Insurance coverage for the Child, please fill out below:

Insurance Co.
Name: _____
Insurance Address: _____
City: _____ State: ____ Zip: _____
Insurance Phone: _____
Group # (Plan, Local, or Policy #): _____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature

Date

Dental History

Why did you bring the child to the dentist today? _____

Has the child ever taken any diet pills such as Phen-Fen? Yes No

(Also known as Redux or Pondimin) if so, when? _____

Is the child currently in pain? Yes No

Does the child require antibiotics before dental treatment? Yes No

Has the child ever had a serious/difficult problem associated with previous dental work?

Yes No

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? Yes No

Has the child ever had pain/tenderness in his/her Jaw joint (TMJ/TMD)? Yes No

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

Floss his/her teeth daily? Yes No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? _____

Please describe the child's current physical health: Good Fair Poor

Please list all prescription/over the counter or herbal supplement drugs that the child is currently taking:

Aside from the items listed, please list all drugs/things that the child is allergic to:

Latex: Yes No Metals/Nickel: Yes No Plastic: Yes No

Medical History

Has the child experienced the following medical problems?

Abnormal Bleeding / Hemophilia	<input type="radio"/> yes <input type="radio"/> no	Heart Murmur	<input type="radio"/> yes <input type="radio"/> no
ADD/ADHD	<input type="radio"/> yes <input type="radio"/> no	Hepatitis	<input type="radio"/> yes <input type="radio"/> no
AIDS/HIV+	<input type="radio"/> yes <input type="radio"/> no	High Blood Pressure	<input type="radio"/> yes <input type="radio"/> no
Anemia	<input type="radio"/> yes <input type="radio"/> no	Hives	<input type="radio"/> yes <input type="radio"/> no
Any Hospital Stays/Operations?	<input type="radio"/> yes <input type="radio"/> no	Kidney Problems	<input type="radio"/> yes <input type="radio"/> no
Artificial Bones/Joints/Valves	<input type="radio"/> yes <input type="radio"/> no	Liver Problems	<input type="radio"/> yes <input type="radio"/> no
Asthma	<input type="radio"/> yes <input type="radio"/> no	Low Blood Pressure	<input type="radio"/> yes <input type="radio"/> no
Cancer	<input type="radio"/> yes <input type="radio"/> no	Lupus	<input type="radio"/> yes <input type="radio"/> no
Chicken Pox	<input type="radio"/> yes <input type="radio"/> no	Measles	<input type="radio"/> yes <input type="radio"/> no
Congenital Heart Defect	<input type="radio"/> yes <input type="radio"/> no	Mitral Valve Prolapse	<input type="radio"/> yes <input type="radio"/> no
Convulsions	<input type="radio"/> yes <input type="radio"/> no	Mononucleosis	<input type="radio"/> yes <input type="radio"/> no
Diabetes	<input type="radio"/> yes <input type="radio"/> no	Prosthetics	<input type="radio"/> yes <input type="radio"/> no
Epilepsy	<input type="radio"/> yes <input type="radio"/> no	Rheumatic Fever	<input type="radio"/> yes <input type="radio"/> no
Exposed to HIV, but Neg.	<input type="radio"/> yes <input type="radio"/> no	Scarlet Fever	<input type="radio"/> yes <input type="radio"/> no
Handicaps/Disabilities	<input type="radio"/> yes <input type="radio"/> no	Skin Rash	<input type="radio"/> yes <input type="radio"/> no
Hearing Impairment	<input type="radio"/> yes <input type="radio"/> no	Tuberculosis (TB)	<input type="radio"/> yes <input type="radio"/> no

Are the child's immunizations current? yes no

Anything you would like to discuss with the Doctor in private? yes no

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

Does/did the child experience any of the following?

- | | | | |
|--------------------------|--|-----------------------|--|
| Breast Fed | <input type="radio"/> yes <input type="radio"/> no | Nursing Bottle Habits | <input type="radio"/> yes <input type="radio"/> no |
| Chewing on Objects | <input type="radio"/> yes <input type="radio"/> no | Speech Problems | <input type="radio"/> yes <input type="radio"/> no |
| Clenching/Grinding Teeth | <input type="radio"/> yes <input type="radio"/> no | Thumb/Finger Sucking | <input type="radio"/> yes <input type="radio"/> no |
| Lip Sucking/Biting | <input type="radio"/> yes <input type="radio"/> no | Tongue/Cheek Biting | <input type="radio"/> yes <input type="radio"/> no |
| Mouth Breather | <input type="radio"/> yes <input type="radio"/> no | Tongue Thrust | <input type="radio"/> yes <input type="radio"/> no |
| Nail Biting | <input type="radio"/> yes <input type="radio"/> no | Used Pacifier | <input type="radio"/> yes <input type="radio"/> no |

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 in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature

Date

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

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Signature of Dentist

Date