We are here to help!
Give us a call today.
317-585-8055

Introduce Your Child:

Today's Date: _____________ Child's Name_______________________________ Nickname: ________________
Child's date of birth: _________________ Age: ________ Gender: ____M ____F
Home Phone: _______________ Home Address: ____
City, State, Zip: ____________________, ________ ______________
School: ___________________________ Grade: ______ Hobbies: _____________________________________
Child's Siblings: ____

Email Address you would like us to use for Office Communication:

Email: ____ for: ____ Mother ____Father

We are HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

General Information:

Who is accompanying the child today? _____________________________ Relation: __________________________
Do you have legal custody of this child? ____Yes ____ No Name of Referrer: _____________________________
Previous Dentist: ___________________________________ Date of Last Visit: ____________________________
Person to Contact in Case of Emergency: _____________________________Relation: ________________
Phone # of Emergency Contact: (____) _____-________

Parent's Information:

Marital Status: ______Single ______ Married ______ Partnered ______ Div ______ Separated

___ Mother ___ Step Mother ___ Grandmother ___Guardian

Name: _____________________________ Date of Birth: ___/___/_____
Home Phone: (____) _____-________ Cell Phone: (____) _____-________ Work Phone: (____) _____-________
Home Address: ____________________________________ City: __________________ Zip: __________
Employer: ___________________________________ O qyj gt'UUP '%

___ Father ___ Step Father ___ Grandfather ___Guardian

Name: _____________________________ Date of Birth: ___/___/_____
Home Phone: (____) _____-________ Cell Phone: (____) _____-________ Work Phone: (____) _____-________
Home Address: ____________________________________ City: __________________ Zip: __________
Employer: ___________________________________ Hcvj gt'UUP '%

Insurance Information:

Person Responsible for Account: _________________________ SS# of Responsible Party _____-____-_____
Insurance Company Name: _____________________________ Insurance Co Phone ________________
Insurance Group Number: _____________________________

I certify that my child is covered by _______________________________ Insurance Company, and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered, and am also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions, whether manual or electronic (print this form and bring to the office to sign).

Signature of Parent/ Guardian: ____ **Date:** __________________

Medical History: Please place a Y or an N

Abnormal Bleeding/ Hemophilia	______	Heart Murmur	______
ADHD/ ADD	______	Hepatitis	______
AIDS/ HIV+	______	High or Low Blood Pressure	______
Anemia	______	Hives	______
Any Hospital Stays/ Operations? Reason ______________	______	Immunizations Up to Date	______
Artificial Bones/ Joints/ Valves	______	Kidney Problems	______
Asthma	______	Liver Problems	______
Autism/ Autism Spectrum	______	Lupus	______
Cancer	______	Measles	______
Chicken Pox	______	Mitral Valve Prolapse	______
Congenital Heart Defect	______	Mononucleosis	______
Convulsions	______	Prosthetics	______
Diabetes	______	Rheumatic Fever	______
Developmental Delays	______	Scarlet Fever	______
Epilepsy	______	Skin Rash	______
Handicaps/ Physical Disabilities	______	Eczema	______
Hearing Impairment	______	Tuberculosis (TB)	______

Are there any additional health problems the child is experiencing? ______ Explain: ______________

Child's Physician: ______________ Last Visit: __________ Phone: (____) _____-________

List all medications your child is taking: ______________

Are there any allergies to: Latex: ___ No ___Yes Metals: ___ No ___Yes Plastic: ___ No ___Yes

Any medication allergies: ___ No ___Yes Explain: ______________

Dental History: Please place a Y or an N

What is the purpose of today's visit? ___ First Visit ___ Routine Cleaning ___Referral ___ Pain ___ Fillings ___ Other

Is the child currently in pain?	______	Is the child taking any fluoride?	______
Are antibiotics required before dental work?	______	Is the child's water fluoridated?	______
Have there been any serious problems associated with previous dental work?	______	Does the child brush his/her teeth?	______
		Do you help?	______
Any tenderness in jaw/ joint (TMJ/ TMD) or any headaches?	______	Frequency?	___ Day ___Wk
		Does your child floss?	______

Does your child now, or did they have a history or experience any of the following:

Breast fed	______	Tongue Thrust Habit	______
Nursing Bottle Habits	______	Mouth Breather	______
Pacifier (now or previous)	______	Clenching or Grinding Teeth	______
Until what age?	___Yrs ___Months	___Nighttime ___Daytime	
Sucks Fingers	______	Tongue or Cheek Biting	______
Sucks Thumb	______	Bites Fingernails	______
Sucks/ Chews on Blanket	______	Speech Problems	______
Chews on Objects	______	Speech Therapy	______

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidences 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 my need.

Signature of Parent/ Guardian: ______________________ Date: __________

******Please complete, print, and sign manually, and bring to your appointment for our records. Thank you.*