abradental℠
FORMERLY CHILDSMILES•FAMILYSMILES

WELCOME TO
OUR PRACTICE

We strive to make every child's visit pleasant and comfortable. Our goal is to teach children good oral habits which will help them keep their smiles beautiful for a lifetime.

How did you heard about us? ○ Friend ○ Family ○ Doctor _____
○ Other _____

About Your Child

Child's name _____
Nickname _____ Sex _____
Birthdate _____ Age _____
School _____ Grade _____
Child's Home Address _____
City, State, Zip _____

Mother ○ Stepmother ○ Guardian
Name _____
Home Phone _____
Cell Phone _____
Work Phone _____
Email _____
Employer _____
Occupation _____

Father ○ Stepfather ○ Guardian
Name _____
Home Phone _____
Cell Phone _____
Work Phone _____
Email _____
Employer _____
Occupation _____

Parents' Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Who is accompanying this child today?

Name _____
Relationship _____
Phone _____
Best time to call _____

Primary Dental Insurance
Insurance's Name _____
Relationship _____
Birthdate _____ Soc. Sec. _____
Employer _____
Date Employed _____
Occupation _____
Insurance Company _____
Group _____ Emp. No. _____
Ins. Company Address _____
Deductible _____ Max. Annual Benefit _____
Orthodontic Coverage? ○ Yes ○ No

Additional Insurance
Insurance's Name _____
Relationship _____
Birthdate _____ Soc. Sec. _____
Employer _____
Date Employed _____
Occupation _____
Insurance Company _____
Group _____ Emp. No. _____
Ins. Company Address _____
Deductible _____ Max. Annual Benefit _____
Orthodontic Coverage? ○ Yes ○ No

Health History (Confidential)

Medical History

Has your child ever had any of the following:

Heart Murmur	○ Yes	○ No
Surgeries/Operations	○ Yes	○ No
Cancer/Tumors	○ Yes	○ No
Hyper Active/ADD	○ Yes	○ No
Respiratory Problems	○ Yes	○ No
Asthma/Difficulty Breathing	○ Yes	○ No
Hemophilia	○ Yes	○ No
Abnormal Bleeding	○ Yes	○ No
Fainting/Seizures/Epilepsy	○ Yes	○ No
Cleft Lip/Palate	○ Yes	○ No
Tuberculosis TB	○ Yes	○ No
Psychiatric Problems	○ Yes	○ No
Cerebral Palsy	○ Yes	○ No
HIV+/AIDS/ARC/HPV	○ Yes	○ No
Diabetes	○ Yes	○ No

Other _____

Please explain any medical problems that your child has:

_____

_____

Does your child require pre-medication? ○ Yes ○ No

Is your child currently taking any medications? ○ Yes ○ No

If yes, please list _____

_____

Is your child allergic to:

○ Latex ○ Tetracycline ○ Penicillin/Amoxicillin

○ Aspirin ○ Food allergies ○ Dental Anesthetics

Other _____

Child's Habits

How often does your child brush? _____

How often does your child floss? _____

Date of last dental visit _____

Previous Dentist _____

Child's Physician _____

Phone Number _____

Address _____

Is your child's water fluoridated? ○ Yes ○ No

Does your child take fluoride supplements? ○ Yes ○ No

_____

Does your child:

Suck thumb/finger	○ Yes	○ No
Suck/bite lips	○ Yes	○ No
Heavy Snoring	○ Yes	○ No
Grind teeth	○ Yes	○ No
Chew hard objects	○ Yes	○ No

_____

_____

Emergency Visit Only

How long has your child been in pain? _____

Explain the problem(s) _____

_____

_____

What type(s) of pain medication has your child been taking? _____

_____

Authorization

I certify that I am covered by insurance with _____

Name of dental insurance company

I assign directly to Abra Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize the doctor to release all information necessary including the diagnosis and records of any examination or treatment provided to my child to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Signature of parent / guardian