



Children's Information Form

Please fill out these forms completely. Return them to our office or fax them to 208-375-7790
The better we communicate, the better we can care for you.

Tell us about your child

Today's Date _____

Child's Name _____
Last First M.I.

Nickname: _____ Male Female

Child's birth Date ___/___/___ Age ___

SS# _____

School: _____ Grade: _____

Child's Home Tel # _____

Home Address: _____
City State Zip

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No

Whom may we thank for referring you? _____

Other family members or friends seen by us: _____

Mother's Information: (Step Mother or Guardian)

Name _____

Work # _____ Home # _____

Employer _____

SS# _____ DL# _____

Father's Information: (Step Father or Guardian)

Name _____

Work # _____ Home # _____

Employer _____

SS# _____ DL# _____

In the event of an emergency is there someone who lives near you that we could contact?

Name _____ Relationship _____

Work# _____ Home# _____

Person Responsible for Account

Name: _____

Billing Address: _____
City State Zip

Work # _____ Home # _____

Employer: _____

SS# _____ DL # _____

Who is responsible for making appointments?

Name: _____

Work # _____ Home # _____

Dental Insurance:

If you have dental insurance and want us to file it for you please provide the following information.

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Insured's Name _____

Relation _____

Insured's Birthday ___/___/___ Insured's SS# _____

Insured's Employer: _____

Do you have any other Dental Insurance Coverage? YES NO

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Group # (Plan Local Policy #) _____

Insured's Name _____ Relation _____

Insured's Birthday ___/___/___ Insured's SS # _____

The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Signature of Parent or Guardian

Date

Child's Medical History

Child's Physician: _____

Physician's Phone # _____

The approximate date of child's
last doctor's visit: ____/____/____

Has the child ever had any of the following medical
problems?

| | |
|-----------------------|------------------------------|
| Y N Heart Murmur | Y N Congenital Heart Defect |
| Y N Cancer | Y N Convulsions/Epilepsy |
| Y N Diabetes | Y N Seizures |
| Y N Rheumatic Fever | Y N Abnormal Bleeding |
| Y N HIV+/AIDS | Y N Any Operations |
| Y N Hemophilia | Y N Any stays in a hospital |
| Y N Asthma | Y N Kidney / Liver Problems |
| Y N Hepatitis | Y N Handicaps / Disabilities |
| Y N Tuberculosis (TB) | Y N Allergies to any drugs |
| Y N Joint Replacement | Y N Hearing Impairment |

Please list any serious medical problems that your child
has had: _____

Please list all drugs that your child is currently taking:

Is your child allergic to any of the following drugs?

Penicillin _____ Aspirin _____

Erythromycin _____ Codeine _____

Dental Anesthetics _____

Is your child allergic to any other drugs? YES NO

Please List _____

Child's Dental History

Has your child been to the dentist before? Yes No

If so, the approximate date of visit: ____/____/____

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

Has your child ever had a serious or difficult
experience with dental work? Yes No

If yes, please explain: _____

Does your child brush their teeth daily? Yes No

Does your child suck fingers, thumb or bite nails? Yes No

Is your child's water fluoridated? Yes No

Does your child take a fluoride supplement? Yes No

Are there any dental problems that you are
aware of at present? Yes No

If yes, please explain: _____

Are you interested in
preventative care for children? Yes No

**Your child will be placed on an automatic
maintenance program unless you request otherwise.**

Do you have any suggestions which you feel would be
helpful treating your child? _____

**I understand that the information that I have
given today is correct to the best of my
knowledge, that it will be held in strictest
confidence and it is my responsibility to
inform the office of any changes in my
child's medical status. I authorize the dental
staff to perform any necessary dental
services my child may need.**

Signature

Date