MegaBiteDental
COSMETIC, IMPLANT, LASER, ORTHODONTIC DENTISTRY

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About Your Child

Today's Date:_____
Email Address:_____
Name:_____
Child's Nickname:_____ ☐Male ☐Female
Birth date: ___/___/___Age:_____SSN:_____
Home Address: _____
_____
Childs' School:_____

Family Information

Person Accompanying Child Today: _____
Relation to Child: _____
Do you have legal custody? ☐Yes ☐No

Mother's Name: _____
Cell#:(___)_____Wk#:(___)_____
Birth date:___/___/___ Employer:_____
Do you live with the child? ☐Yes ☐No
If no – **Address:** _____
_____

Father's Name: _____
Cell#:(___)_____Wk#:(___)_____
Birth date:___/___/___ Employer:_____
Do you live with the child? ☐Yes ☐No
If no – **Address:** _____
_____

Referral Information:

Best time and place to reach parent?_____
Whom may we thank for referring you?_____
Other family/friends seen by us:_____
_____

Dental Insurance

Primary Dental Insurance
Insurance Company Name:_____
Group Plan #:_____
Plan#/Member ID:_____
Insurance Co. Phone #:_____

Secondary Dental Insurance:
Insurance Company Name:_____
Group Plan #:_____
Plan#/Member ID:_____
Insurance Co. Phone #:_____

Emergency Contact Information

Is there another adult that has permission to take your child home, schedule future appointments, and obtain dental/medical information, etc in the event that a parent or guardian cannot? ☐Yes ☐No

His / Her Name:_____
Relation to Child: _____
Hm #:(___)_____ Cell#:(___)_____
Wk#: (___)_____ EXT:_____

I understand that the information that I have given today about my child is correct to the best of my knowledge. I consent to any treatment the dental staff deems necessary for my child, with my informed consent.

_____
Signature Date

Medical History

How would you rate your child's health? ☐ Good ☐ Fair ☐ Poor

Is your child currently under the care of a physician? **Y** **N**

Physician's name:_____ **Wk#**:(___)_____

Has your child been told they need to pre-medicate? **Y** **N**

Is your child taking any prescription/OTC drugs? **Y** **N**

Please list each one**:**

_____

_____

Has your child had any of the following diseases or medical problems?

Y	**N**	Abnormal Bleeding	**Y**	**N**	Heart Murmur
Y	**N**	ADD / ADHD	**Y**	**N**	Heart Surgery/Pacemaker
Y	**N**	Anemia	**Y**	**N**	Hepatitis – A, B, C
Y	**N**	Artificial bones/joints/valves	**Y**	**N**	High/Low Blood Pressure
Y	**N**	Arthritis	**Y**	**N**	HIV+/AIDS
Y	**N**	Asthma	**Y**	**N**	Hospitalized for any reason
Y	**N**	Birth Defects	**Y**	**N**	Kidney Problems
Y	**N**	Blood Transfusion	**Y**	**N**	Liver problems
Y	**N**	Cancer/Chemotherapy	**Y**	**N**	Lupus
Y	**N**	Cleft Lip / Palette	**Y**	**N**	Mitral Valve Problems
Y	**N**	Cerebral Palsy	**Y**	**N**	Psychiatric Problems
Y	**N**	Congenital Heart Defects	**Y**	**N**	Radiation Treatment
Y	**N**	Diabetes	**Y**	**N**	Rheumatic /Scarlet Fever
Y	**N**	Difficulty Breathing	**Y**	**N**	Shingles / Chicken Pox
Y	**N**	Drug/Alcohol Abuse	**Y**	**N**	Sinus Problems
Y	**N**	Epilepsy/Seizures	**Y**	**N**	Stomach Problems
Y	**N**	Fainting Spells	**Y**	**N**	Thyroid Problems
Y	**N**	Fever Blisters/Herpes	**Y**	**N**	Tonsillitis
Y	**N**	Hemophilia	**Y**	**N**	Tumors
Y	**N**	Hearing Problems	**Y**	**N**	Tuberculosis
Y	**N**	Hay Fever/Allergies	**Y**	**N**	Ulcers/Colitis

Other: _____

_____

Is your child allergic to any of the following:

Y	**N**	Aspirin	**Y**	**N**	Erythromycin
Y	**N**	Codeine	**Y**	**N**	Tetracycline
Y	**N**	Penicillin	**Y**	**N**	Latex

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature **Date**

Payment is due in full at time of treatment unless prior arrangements have been approved.

Dental History

What brings you/your child to the office today?

_____

_____

_____

When was your child's last dental exam?

Date: _____

When were your child's last dental x-rays taken?

Date:_____

Name of previous dentist:

_____

How often does your child floss?

#times/day:_____

How often does your child brush?

#times/day:_____

Type of bristles: ☐ Hard ☐ Medium ☐ Soft

Please answer the following questions fully

How would you rate your child's dental health?

☐ Good ☐ Fair ☐ Poor

How would you rate your child's smile?

☐ Good ☐ Fair ☐ Poor

Has your child been told that they require antibiotics before dental treatment? ☐ Yes ☐ No

Has there ever been a serious/significant problem with any previous dental work? ☐ Yes ☐ No

Has your child ever had braces? ☐ Yes ☐ No

Do they grind or clench their teeth? ☐ Yes ☐ No

Have they ever had periodontal treatments (also known as gum treatments?) ☐ Yes ☐ No

Does your child have any of the following:

Y	**N**	Bad Breath	**Y**	**N**	Lesions
Y	**N**	Bleeding Gums	**Y**	**N**	Loose Teeth
Y	**N**	Blisters on Mouth	**Y**	**N**	Lesions
Y	**N**	Broken Fillings	**Y**	**N**	Migraines
Y	**N**	Clicking Jaw	**Y**	**N**	Mouth Pain
Y	**N**	Difficulty Opening/Closing	**Y**	**N**	Mouth Sores
			Y	**N**	Oral Cancer/Lesions
Y	**N**	Difficulty Opening/Closing	**Y**	**N**	Pain (General)
Y	**N**	Difficulty Chewing	**Y**	**N**	Sensitivity to Cold
Y	**N**	Dry Mouth	**Y**	**N**	Sensitivity to Heat
Y	**N**	Ear Pain	**Y**	**N**	Sensitivity to Sweets
Y	**N**	Headaches	**Y**	**N**	Sensitivity to Pressure
Y	**N**	Jaw Pain	**Y**	**N**	Swollen Gums

Other**:**_____

_____