

Welcome

We would like to welcome you and your child to our practice. Our goal is to make every child's visit pleasant and educational. We strive to provide quality care that will enable your child to have a beautiful smile that lasts a lifetime.

| loday's DateWho | om may we thank tor reterr | ing you? |
|--|----------------------------|-----------------|
| Month Day Year | , | 3, |
| ABOUT YOUR CHILD Name | | Nick Name |
| Last | First Initial | NICK Nume |
| Birth DateMa | | |
| Month Day Year | are remare | |
| Hobbies / Sports | | |
| | | |
| Home Address | | |
| | | |
| City | State | Zip |
| , | | _ (|
| Home Phone | Cell Phone | |
| Emergency Contact | | |
| E-mail Address | | |
| Siblings' Names & Ages | | |
| | | |
| ABOUT YOUAccompanying Adult | Relationsh | ip to Child |
| Mother's NameO | | |
| Address/Phone, if different | | |
| Father's NameO | | |
| Address/Phone, if different | Wor | k Phone |
| Person Responsible for Account | | |
| Address | | Phone |
| | | |
| DENTAL INSURANCE COMPANY | | |
| Primary Insurance Co. | Phone# | _Group # |
| Subscriber | SSNDate | of Birth |
| Secondary Insurance Co. | Phone# | _Group # |
| Subscriber | SSNDate | of Birth |
| | | |
| DENTAL HISTORY Age of First Dent | tal VisitDate of La | st Dental Visit |
| Name of Previous Dentist | | |
| How was the child's previous dental expe | | |
| Are there any dental/oral problems that | | Yes No If yes, |
| Please explain | • | |
| Do you have fluoridated water? Yes No | o Do you use water filte | ers? Yes No |
| If you have well water, has it been test | • | Yes No |
| Ts the child taking fluoride supplements | | Ves No |



| How would you describ | be the c | :hild's di | et and eating habits? | | | | | |
|---|-----------|------------|-------------------------------|----------|-------|------|--|--|
| Does the child brush i | regularly | y? Yes | No Floss regularly? | | Yes | No | | |
| Are there any history | of mou | th or jai | w injury ? | | | | | |
| Does the child have any habits that might affect the teeth or bite? | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| MEDICAL HISTORY | Primar | y Physic | ianI | Phone#_ | | | | |
| Is your child currently | y under | the car | e of a physician ? Yes, for | | | _ No | | |
| Date of Last Physical | Check-u | ıp | Immunization Up | to Date | ? Yes | No | | |
| Is the child taking any prescription drug? Yes No If yes, for what reason? | | | | | | | | |
| Please list the drugs | | | | | | | | |
| Is the child allergic to any drug or food? If yes, what reaction | | | | | | | | |
| Please list the drugs or foods | | | | | | | | |
| Has the child ever had any of the following medical conditions or problems? | | | | | | | | |
| Heart murmur | Yes | No | Heart problem of any kind | Yes | No | | | |
| Asthma | Yes | No | Convulsion/epilepsy | Yes | No | | | |
| Diabetes | Yes | No | Rheumatic fever | Yes | No | | | |
| Hemophilia | Yes | No | Bleeding problems of any kind | Yes | No | | | |
| HIV+/AIDS | Yes | No | Cancer | Yes | No | | | |
| Hyperactive | Yes | No | Developmental delay | Yes | No | | | |
| Liver disease | Yes | No | Kidney disease | Yes | No | | | |
| Any operations | Yes | No | If yes, please explain | | | | | |
| Any stays in hospital | Yes | No | If yes, please explain | | | | | |
| If any other medical problems, please explain | | | | | | | | |
| | | | | | | | | |
| I understand that the information that I have given is correct to the best of my knowledge, | | | | | | | | |
| that it will be held in the strictest of confidence, and it is my responsibility to inform this office of | | | | | | | | |
| any changes in the child's medical status. I authorize the release of any information to the insurance | | | | | | | | |
| company in order to process the payments. I authorize Mingchun Chien, D.M.D. and /or Hygienists to perform upon, dental examinations, diagnostic radiography, and | | | | | | | | |
| any necessary dental treatment that has been explained to me. | | | | | | | | |
| any necessary derivative | | 77147 7145 | ocen explained to me. | | | | | |
| Signature of parent of | r auardi | an | Relationshi | n to chi | ld | | | |
| J . , | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Please visit our website for more information about our office at: | | | | | | | | |

www.ConcordChildrensDentist.com