Welcome!

126 E. 29th Street
Loveland, CO 80538
Phone: (970) 635-4353
Fax: (970) 635-4355

PATIENT INFORMATION

Child's Full Name: ____
Last First MI

Preferred Name: ______________________________ Gender: M_____ F_____

Age: ___________ Birthday: ______/______/______ SS#: _____ - ______ - _____

Child's Home Phone #: ________________________

Child's Home Address: ____

City__________________________ State ___________ Zip ___________

Siblings that we treat: ____

School: ____

Mother's Information

Name ______________________________________

Mother Stepmother Guardian Birthday: _____/_____/______

Employer:______________________________________

Work Phone #: ______________ Ext.______

Cell Phone #: ________________ Home Phone #: ________________

SS#: _____________ Driver's License #: ____________________

Father's Information

Name ______________________________________

Father Stepfather Guardian Birthday: _____/_____/______

Employer:______________________________________

Work Phone #: ______________ Ext.______

Cell Phone #: ________________ Home Phone #: ________________

SS#: _____________ Driver's License #: ____________________

Who is accompanying the child today?

Name: ______________________________________

Relationship: ______________________________________

Do you have legal custody of this child? Yes ______ No ______

Person responsible for account

Name: ______________________________________

Relationship: ______________________________________

Billing Address: ______________________________________

____
City State Zip

Home #: _________________ Cell #: _________________

Work #: _________________ Email: ______________________

SS#:________________ Driver's License #: _________________

Who may we thank for referring you?

____

Primary Dental Insurance

Insurance Company Name: ______________________________

Insurance Company Address: ______________________________

____

Insurance Company Phone #: ______________________________

Group # (Plan, Local, or Policy #): ________________________

Policy Owner's Name: ______________________________

Relationship to Patient: ______________________________

Policy Owner's Birthday: ______ / ______ / ______

SS #: ______________________________

Policy Owner's Employer: ______________________________

Secondary Dental Insurance

Insurance Company Name: ______________________________

Insurance Company Address: ______________________________

____

Insurance Company Phone #: ______________________________

Group # (Plan, Local, or Policy #): ________________________

Policy Owner's Name: ______________________________

Relationship to Patient: ______________________________

Policy Owner's Birthday: ______ / ______ / ______

SS#: ______________________________

Policy Owner's Employer: ______________________________

Patient Name:____

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Loveland, CO
80538

Medical History

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

Physician's Name: ____ Phone #: ___________________

Please list all medications your child is currently taking: ____

____

Is your child allergic to any of the following:

Penicillin Sulfa Drugs Ibuprofen Tylenol Aspirin Latex Metals Local Anesthetic

Please list any other drugs your child is allergic to: ____

____

Does your child use tobacco products? Y N

Does your child use any recreational drugs? Y N

Has your child ever had any of the following conditions?

Y N Asthma
Y N Autism
Y N ADD/ADHD
Y N Abnormal Bleeding
Y N Blood Disorders/Hemophilia
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Heart Disease/Murmur
Y N Hepatitis A, B, or C
Y N Hearing Impairment
Y N HIV/AIDS
Y N Hospital Stays/Operations
Y N Kidney Disease
Y N Learning Disability
Y N Liver Disease
Y N Pregnancy
Y N Rheumatic/Scarlet Fever
Y N Stomach Problems
Y N Tuberculosis
Y N Other: ________________________

Does your child have any other medical condition which we need to be aware (please explain):

____

____

Dental History

Is this your child's first dental visit? Y N
When was your child's last dental visit? ___________
Any unhappy dental experiences? Y N
Has your child complained of mouth pain? Y N
How many times a day does your child brush? ________
How often does your child floss? ____________
Do your child's gums bleed while brushing? Y N
Is fluoride taken in any form? Y N

Does your child have any oral habits? Y N
Thumb sucking/pacifier, bottle, sippy cup, nursing, nail biting
Does your child have any sores or lumps in their mouth? Y N
Has your child ever suffered trauma to the face, mouth or jaw? Y N
____
Does your child's jaw pop, click or cause pain? Y N
Does your child clench or grind their teeth? Y N

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. If ever there is a change in my child's health, I will inform the doctors at the next appointment without fail. I authorize the dental staff to perform the necessary dental services my child may need.

____ ____________________________________
Signature of Parent or Guardian Date Relationship to Patient

____
Dentist Signature Date