

Welcome

We would like to welcome you and your child to Dr. Deborah Himelhoch's office. Our goal is to provide professional service in a comfortable child friendly environment. Along with preventive care and orthodontics, we hope to provide both you and your child with the education needed to maintain a healthy smile that lasts a lifetime.

1. Tell us about your child and family:

Today's date: _____

Child's Name: _____ Nickname: _____

_____ Male _____ Female Last First MI Child's Date of Birth: ____/____/____ Child's Age: _____

Child's Home Address: _____

Street Apt/Condo #

City State Zip Code

Parent/Guardian Name: _____ Date of Birth: _____ Relationship to child: _____

Address (if different than child's): _____

Street Apt/Condo #

City State Zip Code

Home phone: _____ Cell phone: _____ E-mail address: _____

Employer: _____ Work phone: _____

Parent/Guardian Name: _____ Date of Birth: _____ Relationship to child: _____

Address (if different than child's): _____

Street Apt/Condo #

City State Zip Code

Home phone: _____ Cell phone: _____ E-mail address: _____

Employer: _____ Work phone: _____

*If your child will be accompanied by someone who is NOT a legal guardian (grandparent, babysitter etc...) please fill out the form titled "Parental Permission" as well as this "welcome" form or contact our office before hand to review medical history.

Parent's Marital Status:

___ Single ___ Married ___ Partnered ___ Separated ___ Divorced

Other family members seen by us: _____

Whom may we thank for referring you? _____

2. Patient's Dental and Medical History

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

Has your child seen a dentist before? If so, when was the last visit? _____ Dentist's name? _____

Has your child had a serious/difficult issue associated with previous dental work? Yes No

Is your child's water fluoridated? Yes No

Is your child taking a fluoride supplement? Yes No

Has your child ever had any pain/tenderness in their jaw? Yes No

Does your child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Does/did your child ever have any of the following habits?

Y N Lip sucking/biting Y N Nursing bottle habit
Y N Nail biting Y N Thumb/Finger sucking

Child's Physician: _____ Phone: _____ Date of Last Visit: _____

Is your child currently under the care of a physician? Yes No

Please describe your child's physical health: Good Fair Poor

Is your child allergic to: Latex? Yes No Metal/Nickel? Yes No Plastic? Yes No

Please list ALL allergies your child has (drugs, food, materials, etc...): _____

Please list ALL medications your child is currently taking: _____

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

Y N Abnormal Bleeding	Y N Autism/PDD/Aspergers	Y N Heart Murmur
Y N ADD/ADHD	Y N Cancer	Y N Hemophilia
Y N Allergies to any drugs	Y N Congenital Heart Defect	Y N HIV+/ AIDS
Y N Any hospital stays	Y N Seizures/ Epilepsy	Y N Kidney/Liver problems
Y N Any operations	Y N Diabetes	Y N Rheumatic/Scarlet Fever
Y N Artificial bones/joints/valves	Y N Handicaps/Disabilities	Y N Sickle Cell Disease/Traits
Y N Asthma	Y N Hearing Impairment	Y N Tuberculosis (TB)

Please discuss any serious medical problems your child has had:

I agree that the information given above is accurate to the best of my knowledge. I understand that it is my responsibility to inform Dr. Deborah Himelhoch's office of any changes in my child's dental or medical history. I authorize the dental staff to perform necessary dental service my child may need.

Signature _____

Date _____

For Dentist's Use Only

For Dentist's Use Only

For Dentist's Use Only

I verbally reviewed the medical/dental information above with the parent or guardian named herein.

Initials: _____

Date: _____

Comments: _____