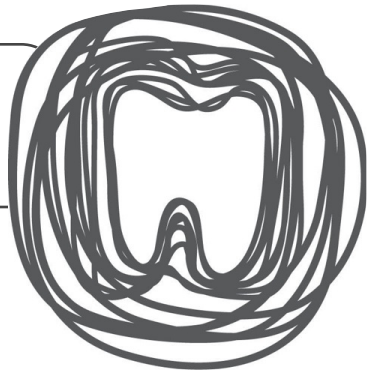
HAGEN
Family & Cosmetic Dentistry
HEATHER HAGEN, D.D.S.

WELCOME



Child Form

1 About Your Child

Today's Date:_____

Child's Name:_____
LAST FIRST MI

Nickname:_____ ☐ Male ☐ Female

Birthdate:____/____/____ Child's Age:____ SS#:_____

Child's Home Address:_____
APT/CONDO #

_____
CITY STATE ZIP

Child's Home #: (____)_____

School: _____ Grade:_____

Hobbies:_____

2 General Information – 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 Siblings:_____

Previous / Present Dentist: _____

Last Visit Date:_____

Dentist's Phone #: (____)_____

Relative or Friend not living with you:

Name:_____ Phone #: (____)_____

3 Parent's Information

Parent Responsible for Account:_____

Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ **Father** ☐ Step Father ☐ Guardian

Name:_____ Birthdate:____/____/____

Address:_____
(if different than Child's)

_____
CITY STATE ZIP

Home #: (____)_____ Cell #: (____)_____

SS #: _____ DL #:_____

Email:_____

Employer:_____

If you have Dental Insurance Coverage for the Child, please fill out below

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #:_____

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

☐ **Mother** ☐ Step Mother ☐ Guardian

Name:_____ Birthdate:____/____/____

Address:_____
(if different than Child's)

_____
CITY STATE ZIP

Home #: (____)_____ Cell #: (____)_____

SS #: _____ DL #:_____

Email:_____

Employer:_____

If you have Dental Insurance Coverage for the Child, please fill out below

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #:_____

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

I certify that my child is covered by_____ Insurance Co. and I assign all insurance benefits other wise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. Signature:_____ Date:___/___/___

4 Medical History

Child's Physician:_____

Phone#: (___)_____ Date of last visit:_____

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

Please Explain: _____

Describe the child's current physical health is:

☐ Good ☐ Fair ☐ Poor

Please list all prescription / over-the-counter or herbal supplement drugs that the child is currently taking :_____

_____

Has the child ever taken diet pills such as Phen-Fen? ☐ Yes ☐ No

Also known as Redux or Pondimin. (if so when?)_____

Has the child experienced the following medical problems?
(Please circle the option that applies)

Y N Abnormal Bleeding / Hemophilia
Y N ADD / ADHD
Y N AIDS / HIV+
Y N Anemia
Y N Any Hospital Stays/Operations
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Hrt Defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Exposed to HIV, but Neg.
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hepatitis
Y N High Blood Pressure
Y N Hives
Y N Kidney Problems
Y N Liver Problems
Y N Low Blood Pressure
Y N Lupus
Y N Measles
Y N Mitral Val Prolapse
Y N Mononucleosis
Y N Prosthetics
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the doctor in private?

☐ Yes ☐ No

List any serious medical condition(s) that the child has ever had:

_____

_____

Is the child allergic to any of the following?

Y N Latex
Y N Dental Anesthetics
Y N Gluten
Y N Metals/Nickel
Y N Penicillin
Y N Other
Y N Plastic
Y N Dairy

Please list any other drugs / things that the child is allergic to:_____

_____

Does / did the child experience any of the following?

Y N Breast Fed
Y N Chewing on Objects
Y N Clenching/Grinding
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech problems
Y N Thumb/Finger Sucking
Y N Tongue/Cheek Biting
Y N Tongue Thrust
Y N Used Pacifier

5 Dental History

Why did you bring the child to the dentist today?

_____

_____

Does the child require antibiotics before dental treatment?

☐ Yes ☐ No

Is the child currently in pain? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Is the child's water Fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

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

_____

Signature **Date**

Reviewed By Dentist

_____

Dr. Signature **Date**