Febres Dentistry For Children, P.A.

Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Carolina Febres, D.D.S.

Tell Us About Your Child

Today's date ______________________

Name ______________________
Last First MI

Preferred Name ______________ ❑ Male ❑ Female

Child's Birth Date ____/____/____ Child's Age ______

School ______________________ Grade ______

Child's Home # ______________________

Child's Home Address

______________________ Apt/Condo # ______

____
City State Zip

Who is Accompanying the Child Today?

Name ______________________

Relationship ______________________

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

Is you child adopted? ❑ Yes ❑ No

How did you hear about our office? ______________

Other family member(s) seen by us ______________

Parent's Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Mother's Information ❑ Step-Mother ❑ Guardian

Name ______________________

Work # ______________________ Ext ______

Home # ______________________

Employer ______________________

Cell # ______________________

Email ______________________

SS# ______________ DOB ______________

Father's Information ❑ Step-Father ❑ Guardian

Name ______________________

Work # ______________________ Ext ______

Home # ______________________

Employer ______________________

Cell # ______________________

Email ______________________

SS# ______________ DOB ______________

Person Responsible for Account

Name ______________________
Last First MI

Work # ______________________ Ext ______

Employer ______________________

DL # ______________________

SS# ______________________

Name of Nearest Relative

Name ______________________
Last First MI

Work # ______________________ Ext ______

Home # ______________________

Primary Dental Insurance

Insurance Co. Name ______________________

Insurance Co. Address ______________________

____

Insurance Co. Phone ______________________

Group # (Plan, Local or Policy #) ______________

Insured's Name ______________________

Relationship to Patient ______________________

Insured's Birth Date ______________________

SS# ______________________

Insured's Employer ______________________

Orthodontic Coverage? ❑ Yes ❑ No

Secondary Dental Insurance

Insurance Co. Name ______________________

Insurance Co. Address ______________________

____

Insurance Co. Phone ______________________

Group # (Plan, Local or Policy #) ______________

Insured's Name ______________________

Relationship to Patient ______________________

Insured's Birth Date ______________________

SS# ______________________

Insured's Employer ______________________

Orthodontic Coverage? ❑ Yes ❑ No

Reason for today's visit ____________________

Please circle one.

- Has the child ever had a bad experience with dental work? **Yes** **No**
- Is the Child **Advanced** **Average** **Delayed** in social development?
- How would you describe the child's personality/temperament? Circle all that apply

  Cooperative **Uncooperative** **Sensitive** **Apprehensive** **Well-adjusted** **Aggressive** **Shy**
- Previous Dentists' name and phone number ____________________
- Last date seen____________________ Last X-Rays taken ____________________
- Is your child's drinking fluoridated water? **Yes** **No**
- How many times a day are your child's teeth brushed?____________________
- Is the child currently using the bottle **Yes** **No** How often? ____________________
- Current dental habits. Please circle if applicable. **Thumb/finger Sucking** **Use Pacifier** **Lip/Cheek Biting** **Nail Biting**
- Previous or current TMJ (jaw) pain, tenderness or popping? ____________________
- Does your child have or ever had recurring headaches **Yes** **No**
- Does your child have allergies to: **Anesthetics, local and general** **Latex** **Sedative Agent** **Drugs or medication** **Food** **Dyes** **Metal** **Acrylic**
- Has the child ever had any of the following medical problems? Please check (✓) all that applies:

__Apnea/snoring
__Asthma
__ADHD/ADD
__Autism
__Bruising easily
__ Blood Transfusion
__Cancer/tumors
__Cerebral palsy
__Cleft lip/palate
__ Heart Defects
__Congenital anomalies
__Convulsions/Seizures
__ Diabetes
__Dizziness
__Growth problems
__Eating disorders
__Endocrine System
__Excessive bleeding
__Frequent infections
__ Physical Disabilities
__Gastrointestinal problems
__Headaches/migraines
__Hearing Impairments
__Heart murmur
__Hemophilia
__Hepatitis
__HIV/AIDS
__Learning disabilities
__Liver or Kidney disorders
__Lung, respiratory problems
__Measles
__Mental retardation
__Mononucleosis
__Mouth breathing
__Mumps
__Prematurity
__Rheumatic fever
__Rubella
__Sickle cell disease/trait
__Sight impairments
__Speech impairments
__Tuberculosis
__Varicella (Chicken Pox)

- Does your child have a heart murmur or condition that requires Antibiotic coverage for dental work? **Yes** **No**
- Please list any serious medical problem that the child has had ____________________

  ____
- Please list all the drug the child is currently taking ____________________

  Frequency ____________________Dose ____________________
- Has the child has any recent infection of bacterial or viral origin? **Yes** **No**
- Is your child currently under the care of a physician **Yes** **No**

Child's Physician____________________Phone____________________Date last seen ____________________

Because your child is a minor, it is necessary that signed permission be obtained from parent or legal guardian before any/ or all necessary dental treatment is performed. Diagnosis of services needed and financial obligation will be discussed with you by the Dr. and/or before treatment is rendered. Your signature authorized Dr. Febres to render the necessary dental treatment, to administer anesthetics, to administer medication, to administer inhalation of nitrous oxide (laughing gas), to take radiographs (x-rays), clinical photographs, study models and other records necessary for accurate diagnosis, to utilize behavior management therapy as needed to provide safe dental care for your child and employ such assistance as is appropriate.

Signature of parent or Legal guardian ____________________Date____________________

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I verbally reviewed the medical /dental information above with the parent/legal guardian and patient named herein. Initials__________ Date___________