JAMES STREET
DENTAL

22 James Street • Geneva, IL 60134 • 630-232-9535

WELCOME

We would like to welcome 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!

TELL US ABOUT YOUR CHILD

Today's Date_____

Child's Name_____

Child's Birthdate___/____/_____ Child's Age_____

Nickname_____ ☐ Male ☐ Female

School_____ Grade_____

Hobbies_____

Home Phone #_____

Home Address_____

Apt/Condo #

_____

City State Zip

GENERAL INFORMATION

Who is accompanying the child today?

Name_____

Relation to Child_____

Do you have legal custody of this child? ☐ YES ☐ NO

Referred by?_____

Other siblings?_____

Previous/Present Dentist_____

Last Visit Date_____ Dentist's Phone #_____

Relative or Friend NOT living with you:

Name_____ Phone #_____

Address_____

_____

City State Zip

PARENT'S INFORMATION

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

☐ Father ☐ Step Father ☐ Guardian ☐ Mother ☐ Step Mother ☐ Guardian

Name_____

Birthdate_____

Address (if different than child's)

_____

SS#_____

Wk#_____ Ext_____ Hm#_____

Email_____ Cell/Other#_____

Employer_____

Employer's Address_____

_____

City State Zip

If you have dental insurance coverage for the child, please fill out

Insurance Company_____

Insurance Address_____

_____

City State Zip

Insurance Phone _____

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

Name_____

Birthdate _____

Address (if different than child's)

_____

SS#_____

Wk#_____ Ext_____ Hm#_____

Email_____ Cell/Other#_____

Employer_____

Employer's Address_____

_____

City State Zip

If you have dental insurance coverage for the child, please fill out

Insurance Company _____

Insurance Address_____

_____

City State Zip

Insurance Phone_____

Group # (Plan, Local or Policy #)_____

RELEASE

I certify that my child is covered by_____Insurance Co. and I assign all insurance benefits otherwise 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 herby 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 of Parent or Guardian Date

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DENTAL HISTORY

Why did you bring the child to the dentist today?

_____

Is the child currently in pain? Y N

Does the child require antibiotics before dental treatment? Y N

Has the child ever had a serious/difficult problem associated with previous dental work? Y N

Is the child's water fluoridated? Y N

Is the child taking fluoridated supplements? Y N

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Y N

Does the child brush his/her teeth daily? Y N

Floss his/her teeth daily? Y N

Child's Physician_____

Phone #_____Date of Last visit_____

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

Please describe the child's current health:
Good Fair Poor

Please list all drugs that the child is currently taking_____

☐ ☐ ☐

_____

Please list all drugs/things that the child is allergic to_____

_____

MEDICAL HISTORY

Has the child experienced the following medical problems?

Y N Abnormal Bleeding	Y N Hepatitis
Y N ADD/ADHD	Y N High Blood Pressure
Y N AIDS/HIV+	Y N Hives
Y N Anemia	Y N Hospitalized/Operations
Y N Artificial Bones/Joints/Valves	Y N Kidney/Liver Problems
Y N Asthma	Y N Low Blood Pressure
Y N Cancer	Y N Measles
Y N Chicken Pox	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Mononucleosis
Y N Convulsions	Y N Prosthetics
Y N Diabetes	Y N Rheumatic Fever
Y N Epilepsy	Y N Scarlet Fever
Y N Handicap/Disabilities	Y N Sickle Cell Dis/Traits
Y N Hearing Impairment	Y N Skin Rash
Y N Heart Murmur	Y N Tuberculosis (TB)
Y N Hemophilia	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

Please discuss any serious medical problems the child experiences (ed)_____

_____

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

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

I affirm that the information I have given 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.

X_____

Signature of patient or parent/guardian if minor Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

_____

Signature of Dentist Date

Dentist Comments_____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If yes, please explain_____

_____

_____ _____

Parent/Guardian Signature Date Dentist Signature Date