Scott A. Welch DDS PA
COSMETIC & FAMILY DENTISTRY

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!

About Your Child

Today's Date: _____

Child's Name: _____
Last First Middle

Child's Birthdate: ____ / ____ / ____ Child's Age: ____

Nickname: _____ ❑ Male ❑ Female

School: _____ Grade: _____

Hobbies: _____

Child's Home Phone: _____ SS#: _____ - ____ - _____

Child's Home Address: _____
Apt./Condo #

_____
City State Zip

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 Number: _____

Relative or Friend not living with you:

Name: _____ Phone: _____

Address: _____
City State Zip

Parent's Information

Person Responsible for Account: _____ Parent's Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Divorced ❑ Separated

❑ Father ❑ Step Father ❑ Guardian

Name: _____ Birthdate: ____ / ____ / ____

Address (if different than Child's): Home Phone: _____

_____
Apt./Condo #

_____
City State Zip

SS#: _____ - ____ - _____ Driver's License #: _____

Wk Phone: _____ Ext: _____ Cell/Other: _____

E-mail Address: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

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

Insurance Company Name: _____

Insurance Company Address: _____

_____
City State Zip

Insurance Company Phone: _____

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

❑ Mother ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: ____ / ____ / ____

Address (if different than Child's): Home Phone: _____

_____
Apt./Condo #

_____
City State Zip

SS#: _____ - ____ - _____ Driver's License #: _____

Wk Phone: _____ Ext: _____ Cell/Other: _____

E-mail Address: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

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

Insurance Company Name: _____

Insurance Company Address: _____

_____
City State Zip

Insurance Company 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 co payment 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 of Parent or Guardian: _____ Date: ____ / ____ / ____

Continued on back...

Scott A. Welch DDS PA
COSMETIC & FAMILY DENTISTRY

Medical History

Has the child ever experienced any of the following medical problems (Please circle):

Y N Abnormal Bleeding/Hemophilia
Y N ADD/ADHD
Y N AIDS/HIV+
Y N Anemia
Y N Hospitalized for Any Reason
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Cancer/Chemotherapy
Y N Chicken Pox
Y N Congenital Heart 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 Valve Prolapse
Y N Mononucleosis
Y N Prosthetics
Y N Rheumatic
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

Please discuss any serious medical problems the child experiences/ed:

_____

_____

_____

Does/did the child experience any of the following (Please circle):

Y N Breast Fed
Y N Chewing on Objects
Y N Clenching/Grinding Teeth
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

Dental History

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

_____

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

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

Is the child currently in pain? ❑ Yes ❑ No

Does the child require antibiotics before dental treatment? ❑ Yes ❑ No

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

Is the child's water flouridated? ❑ Yes ❑ No

Is the child taking flouridated supplements? ❑ Yes ❑ No

Has the child ever experienced pain/tenderness in his/her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

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

Does the child floss his/her teeth daily? ❑ Yes ❑ No

Child's Physician: _____

Physician Phone: _____ Date of Last Visit: _____

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

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

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

_____

Aside from items listed, please list all drugs/things that the child is allergic to: _____

_____

Latex? ❑ Yes ❑ No Metals/Nickel? ❑ Yes ❑ No Plastic? ❑ Yes ❑ No

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.

Signature of Parent or Guardian: _____ Date: _____ /_____ /_____

Medical History Update

Has there been any change in your child's health status since their last visit? ❑ Yes ❑ No

If Yes, please explain: _____

_____

Patient/Guardian Signature: _____

Date: _____ /_____ /_____

Dentist Signature: _____

Date: _____ /_____ /_____

Office Use Only

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

Dentist Signature: _____

Date: _____ /_____ /_____

Doctor's Comments: _____

_____

_____

_____

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

2016-D New Garden Road
Greensboro, NC 27410
www.DrScottWelch.com
336.288.4499