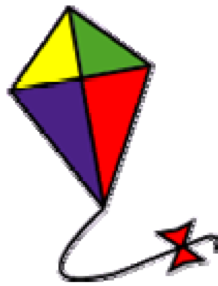

DENTAL CENTER
Children's
OF CENTRAL IOWA, PLC

About Your Child

Patient's name ____________ Birth Date ________ SS# ____________
Preferred name ____________
Male / Female (circle) Siblings(names and ages) ____________
E-Mail address ____________

Responsible Party

Father/male caretaker's name ____________ Birth Date ________ SS# ________
Address ____________ City ____________ State ____ Zip ______
Employer ____________ Occupation ____________
Home Phone ____________ Work Phone ____________
Cell Phone ____________

Mother/Female caretaker's name ____________ Birth Date ________ SS# ________
Address ____________ City ____________ State ____ Zip ______
Employer ____________ Occupation ____________
Home Phone ________ Work Phone ________ Cell Ph. ________
Alternate Contact Name ____________ Phone Number ____________

Dental Insurance Co. and phone number ____________
Card Holder and Social Security Number/ ID number ____________
Patient's Physician ____________ **Referred by** ____________
Medical Insurance Co. and Policy Holder ____________

Dental History

Is this your child's first dental visit? Yes / No
Previous Dentist ____________
Date of last dental visit ____________
Any injuries to your child's teeth or jaws? ____________
History of:
- Breast Feeding Y / N
- Sleeping with a bottle Y / N
- Thumb/Finger sucking Y / N
- Pacifier Y / N
- Dental Grinding/Clenching Y / N

Has our child had and unfavorable dental or medical experience? ____________
How do you think your child will act toward the dentist? ____________
Has your child had recent dental treatment? ____________
Has your child had recent dental pain? ____________
How often does your child brush? ____________ Floss? ____________
Is your child's brushing supervised or assisted? ____________
By whom? ____________
Is dental floss used? Y / N
Does your child receive fluoride vitamins or drops? Y / N

Does your child drink well water? Y / N