Vingelis Lee
PEDIATRIC & FAMILY DENTISTRY
Dr. Kristina Vingelis • Dr. Timothy Lee

WELCOME CHILD

Tell Us About Your Child.

Today's Date:_____ Male: ☐ Female: ☐
Child's Home Phone #:_____ Child's Age: _____
Child's Birthdate:___ /___ /___ Social Security #: _____
Child's Name:_____
Last First M.I.
Nickname: _____
Hobbies: _____
School: _____ Grade: _____
Child's Home Address: _____
Street
_____
City State Zip

Who Is Accompanying The Child Today?

Name:_____ Relation: _____
Do you have legal custody of this child: Yes: ☐ No: ☐
Is the child adopted: Yes: ☐ No: ☐
Is the child in a foster home: Yes: ☐ No: ☐
Whom may we thank for referring you?_____
Other siblings seen by us: _____

Neighbor or Relative not living with you

His/ Her Name: _____ Relation:_____
Work Phone #: (___) _____ Home Phone #: (___)_____
Address: _____
Street
_____
City State Zip

Parents Information

Parents Marital Status: Married: ☐ Divorced: ☐ Seperated: ☐ Widowed: ☐ Remarried: ☐ Single: ☐
Mother: ☐ Step Mother: ☐ Guardian: ☐ Birthdate:___ /___/___ Home Phone #: (___) _____Work Phone #: (___) _____
Name:_____ Social Security #: _____ Driver's License #:_____
Address: _____
Street City State Zip
Employer: _____ Length of Employment: _____
Father: ☐ Step Father: ☐ Guardian: ☐ Birthdate:___ /___/___ Home Phone #: (___)_____Work Phone #: (___) _____
Name: _____ Social Security #: _____ Driver's License #: _____
Address: _____
Street City State Zip
Employer:_____ Length of Employment: _____

Person Responsible for Account

Name: _____ Relationship: Social Security #: _____
Billing Address: _____
Street City State Zip
Work Phone #: (___)_____ Home Phone #: (___)_____
Employer: _____ Driver's License #: _____

Who is responsible for making appointments?

Name: _____ Work Phone #: (___)_____ Home Phone #: (___)_____
Best time to call: _____

Insurance Information

Primary

Medical Coverage? Yes: ☐ No: ☐ Dental Coverage? Yes: ☐ No: ☐ Orthodontic Coverage? Yes: ☐ No: ☐
Insurance Co. Name: _____ Phone #: (___) _____ Group #(Plan, Local, or policy #): _____
Insurance Co. Address: _____
PO Box/Street City State Zip
Policy Owner's Name: _____ Relationship to Patient:_____
Policy Owner's Birthdate: ___ /___/___ Social Security #: _____ Policy Owner's Employer: _____
Employer's Address: _____
Street City State Zip

Secondary

Medical Coverage? Yes: ☐ No: ☐ Dental Coverage? Yes: ☐ No: ☐ Orthodontic Coverage? Yes: ☐ No: ☐
Insurance Co. Name: _____ Phone #: (___)_____ Group #(Plan, Local, or policy #): _____
Insurance Co. Address: _____
PO Box/Street City State Zip
Policy Owner's Name: _____ Relationship to Patient:_____
Policy Owner's Birthdate: ___ /___/___ Social Security #: _____ Policy Owner's Employer: _____
Employer's Address: _____
Street City State Zip

Medical History

Child's Physician: _____ Phone #: ( ) _____ Date of last visit: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? Yes: ☐ No: ☐ Please explain: _____

Please describe the child's current physical health: Good: ☐ Fair: ☐ Poor: ☐ Are Immunizations Current? Yes: ☐ No: ☐

Please list all drugs that the child is currently taking: _____

Please list all drugs/ materials that cause the child allergic reactions: _____

Anything you would like to discuss with the Doctor in private? Yes: ☐ No: ☐ Explain: _____

Has the child had/ experienced any of the following:

Y N Abnormal Bleeding	Y N Diabetes	Y N Low Blood Pressure
Y N AIDS/ HIV+	Y N Epilepsy	Y N Lupus
Y N Anemia	Y N Handicaps/ Disabilities	Y N Measles
Y N Allergies	Y N Hearing Impairment	Y N Mitral Valve Prolapse
Y N Any Hospital Stays/ Operations	Y N Heart Murmur	Y N Mononucleosis
Y N Asthma	Y N Hemophilia	Y N Rheumatic
Y N Blood Transfusion	Y N Hepatitis	Y N Scarlet Fever
Y N Cancer	Y N High Blood Pressure	Y N Sickle Cell Anemia
Y N Chicken Pox	Y N Hives	Y N Skin Rash
Y N Congenital Heart Defect	Y N Kidney Problems	Y N Tonsillitis
Y N Convulsions	Y N Liver Problems	Y N Tuberculosis (TB)

Please discuss any serious medical problems the child experiences/ experienced: _____

_____

Dental History

Is the child currently in pain? Yes: ☐ No: ☐ What is the primary reason for today's vist?

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

Has the child experienced problems with previous dental work? 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: ☐

Previous / Present dentist: _____ Date of last visit: _____
(Please circle one)

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least about? _____

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

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

Authorization

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.
My method of payment will be. _____

_____
Signature of parent or guardian Date

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. _____ 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

The parent or guardian who accompanies the child is responsible for payment at time of service.