



Wall Street Dental

Date ____/____/____

Tell Us About Your Child

Child's Last Name _____ First _____ Middle Initial _____ Nickname _____

Home Phone _____ Cell Phone _____ SSN# _____

Address _____ City _____ State _____ Zip _____ E-mail _____

Birthdate _____ Age _____ Male _____ Female _____ Grade _____ School _____

Parent Information

Parent's Marital Status:

Married _____ Divorced _____ Separated _____ Widowed _____ Remarried _____ Single _____ Partnered _____

Mother: Birthdate _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer _____ SS# _____ Driver's Lic. # _____

Employer's address _____ City _____ State _____ Zip _____

Father: Birthdate _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer _____ SS# _____ Driver's Lic. # _____

Employer's address _____ City _____ State _____ Zip _____

Person Responsible for Bill _____ Relationship _____

Address (if different than above) _____ City _____ State _____ Zip _____

It is okay to contact me by: Home Phone _____ Work Phone _____ Cell Phone _____ Text _____ E-mail _____

May we leave a message regarding dental information at any of the above checked #'s? Yes _____ No _____

If yes, which #'s Home _____ Work _____ Cell _____ Other _____

INSURANCE INFORMATION

Do You Have Dental Coverage? Yes _____ No _____

Primary Insurance

Insured Person's Name _____ DOB _____ SS# _____

Insured's Address _____ City _____ State _____ Zip _____

Insured's Home Phone _____ Work Phone _____ Cell Phone _____ E-mail _____

Relationship to Patient _____ Insurance Co. Name _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Insurance Co. Phone _____ Group# (Plan, Local or Policy#) _____

Insured's Employer _____ Employer's Phone _____

Employer's Address _____ City _____ State _____ Zip _____

Secondary Insurance

Insured Person's Name _____ DOB _____ SS# _____

Insured's Address _____ City _____ State _____ Zip _____

Insured's Home Phone _____ Work Phone _____ Cell Phone _____ E-mail _____

Relationship to Patient _____ Insurance Co. Name _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Insurance Co. Phone _____ Group# (Plan, Local or Policy#) _____

Insured's Employer _____ Employer's Phone _____

Employer's Address _____ City _____ State _____ Zip _____

GETTING TO KNOW YOU

1. Why did you select our office? _____

2. Whom may we thank for referring you? _____

3. Is another member of your family a patient in our practice? (please list name(s))

4. Person for emergency contact _____ Phone#'s _____ Relationship _____

5. When was your child's last dental visit? _____

6. When was the last time you had dental radiographs taken? _____

7. Name of last dentist _____ City _____ State _____ Phone _____

Dental History

Is your child currently in pain yes___no___ What is the primary reason for today's visit_____

Has your child been frightened by a previous dentist or is your child scared to be here today? yes___no___

Has your child experienced problems with previous dental work? yes___no___

Does your child brush his/her teeth daily? yes___no___ Floss daily? yes___no___

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

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

Medical History

Child's Physician_____ Phone #_____ Date of last visit_____

Address_____ City_____ State_____ Zip_____

Is the child currently under a physician's care? yes___no___ Please explain:_____

Please describe the child's current health: good___fair___poor___ Are immunizations current? yes___no___

Please list all drugs the child is currently taking:_____

Besides the following, please list all drugs and/or things that cause the child allergic reactions:

Latex? yes___no___ Metals/Nickel? yes___no___ Plastic? yes___no___ Penicillin? yes___no___ Tetracycline? yes___no___

Anything you would like to discuss with Dr. Yeary in private? yes___no___

Has your child experienced any of the following:

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

Please list any medical problems/conditions your child has:_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that 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 services that my child may need. I assign Dr. Yeary all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and copayment that my insurance does not cover.

Signature:_____ **Date:**_____