VAN DENTISTRY
TAN H. VAN, DDS, P.A.

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WELCOME

Please complete this form in ink. Please advise if you have any questions or need assistance.

Your Child **Today's Date:** _____

Child's Name: _____ Nickname: _____ Sex: F / M Date of Birth: _____

School: _____ Grade: _____

Child's Home Address: _____

Father's Name: _____ Mother's Name: _____

Parent or Guardian Information:

Name: _____ Relationship to Child: _____

Address (if different than above): _____

SS #: _____ DL #: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Do you prefer to receive calls at your: ☐ Home ☐ Work ☐ Cell Phone

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Insurance

Insured's Name: _____ Relationship: _____

SS #: _____ Date of birth: _____ Employer: _____

Insurance Company: _____

Additional Insurance

Insured's Name: _____ Relationship: _____

SS #: _____ Date of birth: _____ Employer: _____

Insurance Company: _____

-OVER PLEASE-

Dental/Medical Health History (Confidential)

How often does your child brush? _____

How often does your child floss? _____

	Yes	No
Is your child's water fluoridated?	☐	☐
Does your child take fluoride supplements?	☐	☐
Does your child:	☐	☐
Suck thumb / finger	☐	☐
Suck / Bite lip	☐	☐
Bite / Chew Nails	☐	☐
Chew hard objects (i.e. pencils, pens etc…)	☐	☐
Grind teeth	☐	☐
Clench jaws	☐	☐
Has your child had difficulty with previous dental visits?	☐	☐
Has your child ever taken Fen-Phen/Redux?	☐	☐

Date of last dental visit? _____

Previous Dentist: _____

Has your child ever had any of the following:

	Yes	No
Asthma	☐	☐
Handicaps/Disabilities	☐	☐
Cancer	☐	☐
Tuberculosis	☐	☐
Hepatitis	☐	☐
Diabetes	☐	☐
HIV/AIDS	☐	☐
Rheumatic Fever	☐	☐
Hemophilia	☐	☐
Congenital Heart Defect	☐	☐
Abnormal Bleeding	☐	☐
Heart Murmur	☐	☐
Stomach, Liver or Kidney Problems	☐	☐
Convulsions/Epilepsy	☐	☐
A persistent cough or throat clearing not associated with a Known illness (lasting more than 3 weeks)	☐	☐

Child's Physician: _____ Phone #: _____

Address: _____

Previous hospitalizations/surgeries/serious illnesses: When:

_____ _____

_____ _____

Is your child currently taking any medications? ☐Yes ☐No If yes, please list: _____

Does your child have a history of allergies/adverse reactions to any drugs/medications (i.e. Penicillin, Novocain etc…) ☐ Yes ☐ No

If yes, please state: _____

Does your child have a history of allergies to any other substances (latex, environmental, etc…)? _____

Please explain any medical problems that your child has: _____

_____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ Date: _____

Signature of Parent/Guardian