Sophia Nichols, DMD, MAGD, PA
General & Cosmetic Dentistry

Welcome
Children's Patient Form

IMPORTANT: If you are a new patient and this is your first time visiting Dr. Sophia Nichols, please fill out in advance and bring to your visit.

ABOUT YOUR CHILD

Name: Last First Initial

Nickname:

Date of Birth:

SS#: Age:

Special interest, sports or hobbies:

Home Address:

Apt/Condo# City State Zip Code

Home Phone:

ABOUT YOU

Your Name: Last First Initial

Nickname:

Date of Birth:

SS#: Age:

Relationship to child:

Your Home Address if different:

Apt/Condo# City State Zip Code

Home Phone:

Occupation:

Employer:

Work Phone:

Cell Phone:

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.

DENTAL INSURANCE COMPANY #1

Dental Ins. Co.:

Insurance Co. Phone #:

Group / Policy #: :

This Dental Insurance is provided through:

Policy owner's name:

Relationship to child:

Policy owner's SS#

Policy owner's birth date#:

Policy owner's employer:

Employer's Address:

City State Zip Code

DENTAL INSURANCE COMPANY #2

Dental Ins. Co.:

Insurance Co. Phone #:

Group / Policy #: :

This Dental Insurance is provided through:

Policy owner's name:

Relationship to child:

Policy owner's SS#

Policy owner's birth date#:

Policy owner's employer:

Employer's Address:

DENTAL /MEDICAL HISTORY

Has your child been to the dentist before? YES ☐ NO ☐

If yes, the approximate date of last visit?

Are there any dental problems that you are aware of at present? YES ☐ NO ☐

If YES, please explain:

Does your child brush his/her teeth daily? YES ☐ NO ☐

Please rate your child's oral health? GOOD ☐ FAIR ☐ POOR ☐

Is your child currently under the care of a physician? YES ☐ NO ☐

Child's Physician:

His/Her Phone Number:

The Approximate date of last visit:

Please rate your child's medical health: GOOD ☐ FAIR ☐ POOR ☐

Is your child allergic to any drugs or other things?: YES ☐ NO ☐
If YES, Please list:

Is your child taking any prescription drugs? YES ☐ NO ☐
If YES, Please list:

Does your child require antibiotics before dental treatment? YES ☐ NO ☐
If YES, why?

Has your child ever had any of the following medical conditions or problems?

YES ☐	NO ☐	Any Hospital Stays
YES ☐	NO ☐	Any Operations
YES ☐	NO ☐	Bleeding Problems of Any Kind
YES ☐	NO ☐	Cancer
YES ☐	NO ☐	Convulsions / Epilepsy
YES ☐	NO ☐	Diabetes
YES ☐	NO ☐	Hearing Impairment
YES ☐	NO ☐	Heart Murmur
YES ☐	NO ☐	Heart Problems of Any Kind
YES ☐	NO ☐	Hemophilia
YES ☐	NO ☐	HIV / AIDS
YES ☐	NO ☐	Hyperactive
YES ☐	NO ☐	Rheumatic / Scarlet Fever

Are there any other medical conditions or problems relating to your child? YES ☐ NO ☐

If YES, Please list:

In the event of an emergency, whom should we contact?

Name: Relationship:

Phone #: Phone #1:

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of 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 by child may need.

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Signature of parent or guardian: Date:
(please print out and sign)

THANK YOU for filling out this form completely. It will enable us to give your child the best dental care possible. If you or your child have any questions, please feel free to ask us at any time.