Información en español al reverso

What to Expect on Your Child's First Dental Visit

Your child's first dental visit should be a pleasant, exciting, and rewarding experience. The Super Dentists, and their crew take special care in how they introduce a youngster to their office. Here's what you and your child can expect...

WHAT HAPPENS ON THE FIRST APPOINTMENT?

Our main concern is to make your child's first visit a pleasant one and to gain his or her trust. The Super Dentists do that by:

- Showing him/her around the office, making your child feel welcome.
- Examining his/her mouth. X-ray pictures may be taken to see how the bones and teeth are growing.
- Suggesting ways to protect your child's oral health through diet and the use of fluorides.
- Teaching both of you how to clean and brush the teeth properly.

Then, if we see anything else that should be done, we plan your child's treatment together with your input.

WHAT SHOULD I TELL MY CHILD BEFORE WE ARRIVE?

Tell your child that The Super Dentists are friendly doctors who help him or her stay healthy. Talk about the visit in a positive way, as you would about any important new experience. A visit to the dentist should be a delightful adventure to your young child.

WHAT ELSE SHOULD I DO?

- DO schedule the visit early in the day. Children usually feel best in the morning and are more cooperative. It's best that your child is rested and the appointment doesn't conflict with his/her meal or nap times.
- DON'T give your child instructions on how to behave in the office such as telling him/her not to cry, sit still in the chair or to be "good," etc.
- DON'T bribe your child to go to the office. DON'T promise any rewards for good behavior.
- DO make appointment days easy ones. See that your child is well rested and that we are the first outing of the day.
- DON'T make other appointments or errands before your dental visit.
- DON'T overdo your preparation. Tell your child about the visit the night before, treating it as a highlight of the next day.
- DO dress up. Nothing increases the expectation of a pleasant experience as much as "getting ready" in nice clothes.

In short, look forward to meeting with us. The Super Dentists look forward to meeting with you and your child. A pleasant beginning makes for a rewarding child-dentist relationship in the long run.

For more information, please visit www.TheSuperDentists.com

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ENGLISH

Patient Information (confidential)

Patient's Name _____ Male Female (CIRCLE ONE)
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Home Phone _____ Birthdate _____ Social Security # _____

How did you hear about our practice? (Please be specific) _____

Responsible Party Information

Name _____
LAST FIRST MIDDLE MARITAL STATUS

Mailing Address _____
STREET CITY STATE ZIP

Work Phone _____ Home Phone _____ Cell Phone _____

Email _____ Relationship to patient _____

Social Security # _____ Birthdate _____ Drivers lic# _____

Employer _____ Occupation/Rank _____

Dental Insurance Information

First Policy

Policy Holder's Name _____ Social Security # _____ Birthdate _____

Insurance Company _____ Group/Policy# _____ Insurance ID# _____

Policy Holder's Employer _____ Relationship to patient _____

Additional Policy

Policy Holder's Name _____ Social Security # _____ Birthdate _____

Insurance Company _____ Group/Policy# _____ Insurance ID# _____

Policy Holder's Employer _____ Relationship to patient _____

Emergency Contact (other than responsible party)

Name _____ Relationship to patient _____
LAST FIRST

Residence _____
STREET CITY STATE ZIP

Email _____ Cell Phone _____

Please complete other side ▶

Medical history / Update

Child's Physician _____ Phone _____

Address _____
STREET CITY STATE ZIP

Date of last physical exam _____ Results _____

Is child under care of physician now? Yes ___ No ___ If yes, why _____

Is child receiving any medication or drugs? Yes ___ No ___ If yes, why _____

_____

Ever been hospitalized? Yes ___ No ___ If yes, why _____

Ever had surgery? Yes ___ No ___ If yes, why _____

Has child had any history of or difficulty with any of the following? Please check Y or N

Y__ N__ A.I.D.S./H.I.V.	Y__ N__ Cerebral Palsy	Y__ N__ Hay Fever	Y__ N__ Mental Disability
Y__ N__ Anemia	Y__ N__ Cleft Lip/Palate	Y__ N__ Hearing Problems	Y__ N__ Rheumatic Fever
Y__ N__ Bladder Problems	Y__ N__ Convulsions	Y__ N__ Heart Problems	Y__ N__ Sinus Problems
Y__ N__ Blood Transfusion	Y__ N__ Developmental Disabillity	Y__ N__ Hepatitis	Y__ N__ Thyroid Disease
Y__ N__ Bruise Easily	Y__ N__ Diabetes	Y__ N__ Jaundice	Y__ N__ Tuberculosis
Y__ N__ Cancer	Y__ N__ Epilepsy	Y__ N__ Kidney Disease	Y__ N__ Premature
Y__ N__ Phen Phen	Y__ N__ Fainting	Y__ N__ Liver Disease	Other_____

Any medications taken? (including Bisphosphonate) Yes__ No__ Other:_____

Has child ever had any asthmatic attacks? If yes, Mild ___ Moderate ___ Severe ___ Frequency _____

Is child allergic to, or ever had an adverse reaction to the following? Please check Y or N

Aspirin Y__ N__ Barbituates Y__ N__ Sedatives Y__ N__ Sulfa Drugs Y__ N__ Any others _____

Amoxicillin Y__ N__ Local Anesthetics Y__ N__ Sleeping Pills Y__ N__ Latex Y__ N__

Does child have any dental pain? Yes__No__If yes, please list:_____

Does child have any habits? (thumb sucking, biting or chewing) Yes__No__If yes, please list:_____

_____

Dental History

Is this your child's first time to a dental office? Yes ___ No ___ If no, please complete the following:

Name of previous dentist _____ Phone _____

Date of last visit to dentist _____ For what services _____

Has your child had any trouble associated with any previous dental treatment? Yes ___ No ___

Have you been satisfied with your child's previous dental care? Yes ___ No ___

OFFICE USE ONLY

Doctors Name: _____ **Doctors Signature:** _____

Authorization

I hereby authorize the dentists and staff to perform all necessary treatment and diagnostic aids when necessary, as the standard of care to properly diagnose, treat and record any and all dental conditions. To the best of my knowledge the information I have given on this form is correct, and 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 understand the use of anesthetic agents embodies certain risks. I understand that I am financially responsible for all charges and services rendered whether or not it is covered by my insurance as well as all broken appointment fees and all late payment service charges. I understand that obtaining insurance coverage and benefit information is MY RESPONSIBILITY and NOT the responsibility of our office or dental staff. This consent is to remain in effect from the date indicated until cancelled in writing.

Signature of Responsible Party _____ Date _____