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
# Patient Information (confidential)

**Patient's Name**

<table>
<thead>
<tr>
<th>LAST</th>
<th>FIRST</th>
<th>MIDDLE</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

**Address**

<table>
<thead>
<tr>
<th>STREET</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
</table>

**Home Phone**

**Birthday**

**Social Security #**

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

# Responsible Party Information

**Name**

<table>
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<tr>
<th>LAST</th>
<th>FIRST</th>
<th>MIDDLE</th>
<th>MARITAL STATUS</th>
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**Mailing Address**

<table>
<thead>
<tr>
<th>STREET</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
</table>

**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 #**

**Birthday**

**Insurance Company**

**Group/Policy #**

**Insurance ID #**

**Policy Holder's Employer**

**Relationship to patient**

## Additional Policy

**Policy Holder's Name**

**Social Security #**

**Birthday**

**Insurance Company**

**Group/Policy #**

**Insurance ID #**

**Policy Holder's Employer**

**Relationship to patient**

# Emergency Contact (other than responsible party)

**Name**

<table>
<thead>
<tr>
<th>LAST</th>
<th>FIRST</th>
<th>Relationship to patient</th>
</tr>
</thead>
</table>

**Residence**

<table>
<thead>
<tr>
<th>STREET</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
</table>

**Email**

**Cell Phone**

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Please complete other side
Medical history / Update

Childs 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 Disability  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

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__  Sulfur 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 childs 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 childs 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 knowl-
edge the information I have given on this form is correct, and I understand that providing incorrect information
can be dangerous to my childs 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 ___________________________