

4949 Westown Pkwy "Suite 150 West Des Moines, IA 50266-6716 (515) 225-0066

tell us about your child

Today's Date:	Child's H	Home Phor	ne #:			
Child's Name:						
=	Child's Birthdate:		Child's Age:	□ Male □	I Female	
Child's Home Address:			_			
Whom may we thank for re	Street	City	State	Z	ip	
	Phon	Да #·	Relations	nin #:		
Emergency Contact Name.	1 11011		110101131	пр #		
	parent info	rmatio	n			
Parent's Marital Status:	Married ☐ Divorced ☐ Separ	rated □ W	idowed □ Sinale □	Partnered		
	Step Parent Guardian Do				No	
Please list anyone else who has custody	of this child and/or any other custody arrang	gements that we	should be aware of:			
Name:		Socia	l Security #:			
Birthdate:	Home Phone #:		Work Phone #:			
Email Address:			Cell Phone #:			
Address:	Street	City	State	Z	in	
Employer:						
Parent:	Step Parent 🚨 Guardian Does t	his person ha	ve custody of this child?	☐ Yes ☐ No		
Name:		Socia	l Security #:			
Birthdate:	Home Phone #:		Work Phone #:			
Email Address:			Cell Phone #:			
Address:	Street	City	State	7	lip S	
Employer:	Street	•	_Occupation:		ір 	
	insurance inf	format	ion		•	
Primary Insurance	Dental Coverage? ☐ Yes ☐ No	o Ort	hodontic Coverage?	☐ Yes ☐ No		
-	Phone #:		_		_	
Insurance Co. Address:			. , , , , , , , , , , , , , , , , , , ,		K	
Insured's Name	PO Box/Street	Relation	City State nship to Patient:		Zip	
			•			
	Dental Coverage? ☐ Yes ☐ No Phone #:				8	
Incurance Co. Address	FIIUIIE#.	GI	σ υρ π (Fiaii, Local, or Polic	y #)		
Insurance Co. Address	PO Box/Street	.	City State		Zip	
					•	
					R	
insured's Employer:						
			continu	ed on bo	ack	

Is the child experienced problems with previous dental work? Yes No No No No No No No N		dentalh	story	
Has the child experienced problems with previous dental work? Yes No Does the child brush his / her teeth daily? Yes No Floss his / her teeth daily? Yes No Previous / Present Dentist: Date of last visit: Please Crow Does / did the child have any of the following habits? I go sucking / Biting Clenching / Grinding Teeth Tongue / Cheek Biting Mouth Breather Nail Biting Thumb / Finger Sucking Used Pacifier Speech Problems I Chewing on Objects Nursing Bottle Habits Tongue Thrust Breast Fed	Is the child currently in pair	n? ☐ Yes ☐ No What is the prir	mary reason for today's visit?	
Does the child brush his / her teeth daily?		·	•	
Previous / Present Dentist:	·	·		□No
Previous / Present Dentist: Does / did the child have any of the following habits? Dig Sucking / Biting Clenching / Grinding Teeth Tongue / Cheek Biting Mouth Breather		,		
Please Circle Does / did the child have any of the following habits? Lip Sucking / Biting	•			
□ Lip Sucking / Bitling □ Clenching / Grinding Teeth □ Tongue / Cheek Bitling □ Mouth Breather □ Speech Problems □ Chewing on Objects □ Nursing Bottle Habits □ Tongue Thrust □ Breast Fed	Please Circle			
□ Nail Biting □ Thumb / Finger Sucking □ Used Pacifier □ Speech Problems □ Chewing on Objects □ Nursing Bottle Habits □ Tongue Thrust □ Breast Fed			E.T / Ob I. Biti	EM. II. Double
Child's Physician: Phone #: Date of last visit: Address: Street City State Zip Is the child currently under the care of a physician? Pes No Please explain: Please describe the child's current physical health: Good Fair Poor Are the child's immunizations current? Pes No Please explain: Please list all drugs that the child is currently taking: Besides the following, please list all drugs and/or things that cause allergic reactions: Latex? Pes No Metals/Nickel? Pes No Plastic? Pes No Penicillin? Pes No Penici		ŭ ŭ		
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www.dmpdc.com

Date

Signature

Rev. Date 8/18