WELCOME TO DR. McCUIN'S OFFICE

Child's Information

Child's Name: ______________________________________
Address: ____
City: ____________________ State: _____ Zip: __________
Phone #: __________________ Date of Birth: ____________
Hobbies/Sports/ Interests ____________________________

Person responsible for this account: _____________________
Address: ____
City: ____________________ State: _____ Zip: _________
Employed by: _______________________________________
Business Address: ___________________________________
City: ____________________ State: _____ Zip: _________
SSN: ______________________
Dental Insurance Plan: ______________________________

Referred by: _______________________________________

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made please remember this time has been reserved for the patient.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are filed directly to insurance and that the patient may be responsible for co-payment or a portion of the fees on the day services are rendered. Once your claim has been paid by the insurance company patient may receive a bill for any additional amounts not covered.

Signature: _____________________________________
Date: ______________________________

Dental History

Chief oral complaint __________________________________
Date of last dental exam: _____________________________
Any unfavorable dental experience? yes no
If yes please explain: _________________________________
____

What texture toothbrush does the child use? ______________
How frequent does he/she brush? _______________________

Does your child have or use any of the following?
Please mark only the ones that apply.

___ Traumatic injury to teeth or mouth
___ Teeth sensitive to cold, heat, sweets or pressure
___ Bleeding gums, how long
___ Clenching or grinding of teeth
___ Frequent blisters on lips or mouth
___ Swelling or lumps in mouth
___ Complications from extractions
___ Oral habits: thumb sucking, fingernail biting, cheek biting
___ Disclosing tablets or solution
___ Pain around ear
___ Topical fluoride
___ Orthodontic treatment
___ Fluoride supplements
___ Well balanced diet
___ Bad breath
___ Mouth breathing
___ Dental floss
___ Between meal snacks

Medical History

Child's Physician: ___________________________________
Date of last physical exam: ___________________________
Childs age: ____________
Does he/she have allergies to any medications? __________
If yes, which ones? ___________________________________

Is he/she currently taking any medications? _____________
If yes, which ones? ___________________________________
____

Does your child have or use any of the following?
Please mark only the ones that apply.

___ Excessive bleeding from cut or extraction
___ Psychiatric care/ emotional problems
___ Extreme nervousness or apprehension
___ Immune system disorders (AIDS, HIV, ARC)
___ Allergy to penicillin
___ Allergies to anesthetics
___ Allergies in general
___ Anemia or blood problems
___ Liver problems/hepatitis
___ Malignances or Leukemia
___ Physical or mental handicap
___ Rheumatic fever
___ Tonsillitis
___ Any heart ailments
___ Hay fever
___ Diabetes
___ Asthma
___ Kidney problems
___ Sinus problems
___ Thyroid disorders
___ Eye disorders
___ Ulcer or colitis
___ Other ____