S. ALBERT CAVES, D.M.D.
5900 RIVER ROAD, SUITE 302 • COLUMBUS, GEORGIA 31904 • 706-571-0079

Welcome to Dr. Caves' Office!

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

Tell Us About Your Child

Today's Date _____

Child's Name: _____
Last First Mi

Child's Birthdate: _____ / _____ / _____ Child's Age _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade _____

Hobbies: _____

Child's Home #: (_____) _____ SS# _____

Child's Home Address: _____
Apt/Condo #

_____
City State Zip

General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? _____

Other siblings: _____

Previous / Present Dentist: _____

Date of Last Dental Visit: _____

Dentist's Phone #: (_____) _____

Relative or Friend not living with you:

Name: _____ Phone: (_____) _____

Address: _____

_____
City State Zip

Parent's Information

Who is responsible for account? _____ Parents Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ **Father** ☐ Step Father ☐ Guardian

Name: _____ Birthdate: ____ / ____ / ____

Address: (If different than Child's)

_____

_____

SS #: _____ DL # _____

Wk #: (_____) _____ Ext. _____ Hm #: (_____) _____

Email: _____ Cell/Other #: (_____) _____

Employer: _____

Employer Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (_____) _____

Group # (Plan, Local, or Policy #): _____

☐ **Mother** ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: ____ / ____ / ____

Address: (If different than Child's)

_____

_____

SS #: _____ DL # _____

Wk #: (_____) _____ Ext. _____ Hm #: (_____) _____

Email: _____ Cell/Other #: (_____) _____

Employer: _____

Employer Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (_____) _____

Group # (Plan, Local, or Policy #): _____

Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of Parent or Guardian Date

CONTINUED ON BACK

Dental & Medical History

Why did you bring the child to the dentist today? _____

_____

_____

Has the child ever taken any diet pills such as Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin) If so, when? _____

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever has a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking:

_____

_____

Please List all drugs/things that the child is allergic to:

_____

_____

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Heart Murmur
Y	N	ADD/ADHD	Y	N	Hemophilia
Y	N	AIDS/HIV+	Y	N	Hepatitis
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Any Hospital Stays/Operations?	Y	N	Hives
Y	N	Artificial Bones/Joints/Valves	Y	N	Kidney / Liver Problems
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Cancer	Y	N	Measles
Y	N	Chicken Pox	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Mononucleosis
Y	N	Convulsions	Y	N	Prosthetics
Y	N	Diabetes	Y	N	Rheumatic Fever
Y	N	Epilepsy	Y	N	Scarlet Fever
Y	N	Exposed to HIV, but Neg.	Y	N	Sickle Cell Disease/Traits
Y	N	Handicaps/Disabilities	Y	N	Skin Rash
Y	N	Hearing Impairment	Y	N	Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experiences/ed:

_____

_____

Does/did the child have any of the following habits?

Y	N	Breast Fed	Y	N	Nursing Bottle Habits
Y	N	Chewing on Objects	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Thumb/Finger Sucking
Y	N	Lip Sucking/Biting	Y	N	Tongue/Cheek Biting
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Used Pacifier

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the AHA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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 my child may need.

_____
Signature of Parent or Guardian Date

Office Use Only

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein. _____
Signature of Dentist Date

Dentist's Comments: _____

_____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Yes ☐ No
If Yes, Please explain. _____

_____

Has there been any change in your child's health status since their last visit? ☐ Yes ☐ No
If Yes, Please explain. _____

_____

_____
Parent/Guardian Signature Date

_____
Dentist Signature Date

_____
Parent/Guardian Signature Date

_____
Dentist Signature Date