



PATIENT INFORMATION

CHILD'S FULL NAME: _____ NICK NAME: _____

CHILD'S BIRTH DATE: _____ AGE: _____ SEX: (Circle) M F

CHILD LIVES WITH: (Circle) **Both Parents** **Mother** **Father** **Guardian** **Grandparents**

CHILD'S HOME ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

ALTERNATE NUMBER - Emergency
(Friend, neighbor, relative, etc.)

Name: _____ Relationship to Child: _____ Phone: _____

REFERRAL SOURCE

We appreciate the referral of patients to our office and like to send a special "thank you". Whom may we thank for referring you to us?

Name: _____ Relationship: _____

PARENT INFORMATION

FATHER'S FULL NAME: _____ MOTHER'S FULL NAME: _____

Father Employed By: _____ Mother Employed By: _____

Social Security #: _____ Social Security #: _____

Driver's License # _____ Driver's License #: _____

Employer Phone #: _____ Employer Phone #: _____

Birth Date: _____ Birth Date: _____

DENTAL INSURANCE INFORMATION

Insured Party's Name: _____ Relationship to Child: _____

Employer: _____ Insurance Co.: _____

Group #: _____ Insurance Phone #: _____

Contract # _____

IF MORE THAN ONE INSURANCE COVERAGE, PLEASE COMPLETE:

Insured Party's Name: _____ Relationship to Child: _____

Employer: _____ Insurance Co.: _____

Group #: _____ Insurance Phone #: _____

Contract #: _____ Insurance Phone #: _____

Payment for services is required at each appointment.
The adult who brings the child to the office is financially responsible.

It is your responsibility to inform us of any changes in your child's health. Thank you.

Family Physician or Pediatrician: _____

MEDICAL HISTORY

| CONDITION | YES | NO | CONDITION | YES | NO | CONDITION | YES | NO |
|----------------------------|-----|----|--------------------------|-----|----|----------------------|-----|----|
| AIDS or HIV Positive | | | Counseling | | | Hyperactivity | | |
| Acid Reflex/GERD | | | Cystic Fibrosis | | | Kidney Disorder | | |
| Artificial Prosthesis | | | Developmentally Impaired | | | Muscular Dystrophy | | |
| Asthma | | | Diabetes | | | Motor Skills Delayed | | |
| Attention Deficit Disorder | | | Eating Disorder | | | Radiation Treatment | | |
| Bleeding Disorder/Anemia | | | Epilepsy | | | Rheumatic Fever | | |
| Blood Transfusion | | | Hearing Impaired | | | Shunt | | |
| Brain/Nerve Damage | | | Heart Disorder/Surgery | | | Speech Delayed | | |
| Cerebral Palsy | | | Heart Murmur | | | Surgery | | |
| Chemotherapy | | | Hepatitis/Liver Disorder | | | Vision Impaired | | |
| Tuberculosis | | | Autism | | | | | |
| Other _____ | | | | | | | | |

Please explain any YES answers or other health problems: _____

Is your child allergic to Penicillin Erythromycin Ceclor Sulfa Other _____
 Food Medicine Environmental

Taking any medicine now? (Circle) YES NO Explain: _____

At the appropriate grade level for his/her age? (Circle) YES NO Explain: _____

Is there anything in the patient's background that we should know to help us better relate to him/her? (Circle) YES NO If yes, explain below:

DENTAL HISTORY

Any previous dental experience? (Circle) YES NO Where: _____

What was done: _____ When: _____

Child's reaction: _____ Parent's reaction: _____

Main dental concerns: _____

Has your child ever had injuries to the head or neck? (Circle) YES NO Explain: _____

Does your child have any oral habits? (Circle) Thumb Finger Pacifier Other _____

Who brushes your child's teeth? _____ When? _____

Names and ages of other children in the household: _____

DIETARY HISTORY

Does your child snack frequently? (Circle) YES NO On what? _____

Does your child drink juice frequently? (Circle) YES NO What kind? _____

Many fruit juices have natural acids which can cause cavities if taken frequently

Does/did your child take a bottle to bed? (Circle) YES NO Explain: _____

Is your home water supply fluoridated? (Circle) YES NO Does your child take a fluoride supplement? (Circle) YES NO

Because your child is a minor, signed permission is required from a parent or guardian for any dental treatment.

Signature: _____ Date: _____

(Parent/Guardian)