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Patient Information

Patient ____ Male or Female ___________ Today's Date _____________

Preferred Name _______________________________________ Birthday ____________________ Age __________

Home Phone ____________________ Phone Secondary ____________________ Cell Phone _______________________

Home Address ____

School____________________________________ Grade ______________________

Names and ages of other children in family ____

Parent or Legal Guardian Information

Parent/Legal Guardian____ Relation to patient _________________

Employer________________________________ Email ___________________________________

Parent/Legal Guardian ____ Relation to patient __________________

Employer ________________________________ Email __________________________________

Who has legal custody of patient? ____

Emergency Contact

Name __________________________________ Relationship _______________________ Phone _____________________

Dental Insurance

Dental Insurance Yes No Name of Insurance Company __________________________________ Group # _______________

Person responsible for payment of account _____________________________ SS# _______________ DOB __________________

Whom may we thank for referring you to us?

____

What is the reason for your child's dental visit?

____

Health History

Yes No Is your child allergic to anything? Please list

____

Yes No Is your child in good health? Date of last physical exam ______________________________________

Yes No Has your child ever had a health problem? ____

Yes No Is your child current on their vaccinations? If no, please explain

____

Yes No Has your child ever been hospitalized? Please give reason and dates

____

____

Yes No Were there any problems at birth?

____

Yes No Is your child currently taking any medications? Please give medication, dose and reason

__________________________________ ____

Physician Name and Phone # ____

Please check if your child has been treated for any of the following:

YES **NO** **YES** **NO** **YES** **NO**

☐ ☐ ADHD/ADD ☐ ☐ Developmental Delays ☐ ☐ Kidney/Bladder Disease

☐ ☐ Anemia ☐ ☐ Diabetes ☐ ☐ Liver Disease/Hepatitis

☐ ☐ Anxiety/Depression ☐ ☐ Down Syndrome ☐ ☐ Malignancies

☐ ☐ Asthma ☐ ☐ Epilepsy/Seizures ☐ ☐ Rheumatoid Arthritis

☐ ☐ Autism/Asperger's ☐ ☐ Fainting ☐ ☐ Sensory Issues

☐ ☐ Cerebral Palsy ☐ ☐ Heart Problems ☐ ☐ Speech Delays

☐ ☐ Chronic Sinusitis ☐ ☐ Heart Murmurs ☐ ☐ Thyroid Problems

☐ ☐ Deaf/Blind ☐ ☐ HIV/AIDS ☐ ☐ Tuberculosis

Please tell us more about any items checked

____

____

Dental History

Yes No Is this your child's first dental visit? If not, date of last visit ____________ Where? ________

Yes No Does your child have any habits? (thumb sucking, pacifier, etc) If so, list ___________________

Yes No Has your child had a bad experience in a dental office?

____

Yes No Does your child drink juice or soda? If so, how much a day?

____

Yes No Did your child nurse or use a bottle after 12 months? _________________________________

Yes No Does your child snack frequently during the day?

____

Yes No Did/does your child nurse or have a bottle during the night? _________________________________

Yes No Has your child had a toothache or any type of oral pain recently?

____

Yes No Do you help your child with brushing? ____

Yes No Has your child ever had a dental injury (bumped or chipped a tooth, bruised lip)?

____

Type of water source? ☐Private Well/without fluoride ☐City Water System/with fluoride

To the best of my knowledge, the answers I have given are accurate. I understand it is important to report changes in my child's medical or dental status to the dentist, and I agree to do so. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment.

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Signature of Parent/Legal Guardian Date