

Patient Information

TELL US ABOUT YOUR CHILD.....

Today's Date ___/___/___

Child's Name _____ Nickname _____ Male Female

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ - _____ Date of Birth ___/___/___ Age ___ Weight ___

Previous/Present Dentist _____ Last Visit Date _____

Whom may we thank for referring you to our office? _____

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

Child's Health History

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

Is the child's water fluoridated? Yes No Is the child taking fluoride 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? Yes No

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Allergies to any drugs | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Any Operations | <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> HIV+/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney/Liver Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Handicaps | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> **Any Hospital Stays | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tuberculosis (TB) |

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DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

- | | |
|--|---|
| <input type="checkbox"/> Lip Sucking/Biting | <input type="checkbox"/> Nail Biting |
| <input type="checkbox"/> Nursing Bottle Habits | <input type="checkbox"/> Thumb/Finger Sucking |

Child's Pediatrician/Physician _____ Phone _____ Last Visit _____

Has the child had any serious medical problems? _____ If yes, explain: _____

Please list all drugs that the child is currently taking: _____

Please list all drugs that the child is ALLERGIC to: _____

Parent/Guardian Information

Mother's Name _____ Mother Guardian Birth Date ____/____/____

Work # _____ Ext. _____ Employer _____ Cellular # _____

Home # _____ SS# _____ - _____ - _____ DL# _____

Father's Name _____ Father Guardian Birth Date ____/____/____

Work # _____ Ext. _____ Employer _____ Cellular # _____

Home # _____ SS# _____ - _____ - _____ DL# _____

Parent's Marital Status: Married Single Separated Divorced Widowed

Person to contact in case of Emergency Outside of Immediate Family Household

Name _____ Phone _____

Insurance Information

PRIMARY DENTAL INSURANCE

Insurance Co _____

Address _____

Phone _____

Group # _____ Policy # _____

Insured's Name _____

Do you have orthodontic coverage? Yes No

SECONDARY DENTAL INSURANCE

Insurance Co _____

Address _____

Phone _____

Group # _____ Policy # _____

Insured's Name _____

Do you have orthodontic coverage? Yes No

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of 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/Guardian

Date

UPDATE (To be completed later) I have reviewed and updated all information on this form.

Signature _____	Date _____
Signature _____	Date _____
Signature _____	Date _____
Signature _____	Date _____