Patient Information

Name: ______________________________________
DOB: ____________ Age: ____________ Sex: M or F

Address: ____________________________________
City: _______________State: ________ Zip:

EMAIL ADDRESS: MOM/DAD____
Pharmacy and Location: ____

PARENT/GUARDIAN INFORMATION:

Father: Stepfather/Guardian/Other____

Name: ________________________________DOB: ____________________ SS# _________________

Address: (if different from child) ____

Place of Employment: (if military a unit address is mandatory) ____________________ Work# ________________

Home Phone# _______________________________ Cell Phone# _______________________________

Mother: Stepmother/Guardian/Other ____

Name: ________________________________DOB: ____________________ SS# _________________

Address: (if different from child) ____

Place of Employment: (if military a unit address is mandatory) _____________________Work# ________________

Home Phone# _______________________________ Cell Phone# _______________________________

INSURANCE: Name of Insurance Policy: ____

Do you have more than one insurance policy for your child? YES/NO
If yes, please provide name of secondary insurance policy: ________________________________

DENTAL HISTORY:

Why is your child here today? ____
Is this your child's first visit to the dentist? _______ If no. when was the last visit? ________________
Will your child be a cooperative patient? ____

Please describe how your child will behave today. Circle all that may apply:
Friendly Happy Timid Afraid Resistant
Does your child receive fluoride in any form? YES/NO If yes, what kind? ______________________
Has your child inherited any dental characteristics? _____________________________________
Have there been any injuries to your child's teeth? _____________________________________
Has your child had any of the following problems? Circle all that apply:
Cavities Toothache Bad Breath Crooked Teeth Sensitive to Sweets
Bleeding Gums Sensitive to Hot/Cold Frequent Headaches Jaw Pain
Discolored Teeth Loose Teeth Teeth Bumped TMJ Popping/Clicking

Does your child have any of the following oral habits? Circle all that apply:
Thumb Sucking Lip Biting Teeth Grinding Pacifier Use

How often does your child brush their teeth? ____________________ Floss? ______________________
At what age did your child stop using the bottle? _________ Sippy Cup? ________ Still Nursing? ______

MEDICAL HISTORY

Child's Physician: ____

Address: ____ Phone # _____________________

Is your child in good general health? YES NO

If no, please describe: ____

Does your child have any physical disabilities/developmental delays? YES NO

If yes, please describe: ____

Are your child's immunizations and booster shots up to date? YES NO

Has your child had any surgical procedures? YES NO

If yes, for what reason? ____

Has your child had or do they now have:

1. Allergies: YES or NO
   - Latex Allergy: YES or NO
   - Seasonal Allergies: ____
   - Food Allergies: ____
   - Drug Allergies: ____
2. Has your child had any history of asthma or breathing problems? ________________________________
   - What induces their breathing problems? ____
   - What asthma medication does your child take? ____

PLEASE CIRCLE YES/NO TO ALL CONDITIONS LISTED BELOW

3. Autism Spectrum	Yes No	14. Hearing/Vision Impairment	Yes No	25. Steroid therapy or chemotherapy	Yes No
4. Sensory Integration Issues	Yes No	15. Eating Disorder	Yes No	26. Nervous or Emotional Disorder	Yes No
5. ADD/ADHD	Yes No	16. Abnormal Bleeding	Yes No	27. Convulsions or seizures	Yes No
6. Heart trouble/murmur	Yes No	17. Prolonged bleeding/Transfusions	Yes No	28. Date of last seizure: ________________	
7. Rheumatic heart disease/fever	Yes No	18. Birth defects	Yes No	29. Frequent diarrhea or vomiting	Yes No
8. Blood disease/anemia	Yes No	19. Kidney Disease	Yes No	30. Mumps, measles, chickenpox	Yes No
9. AIDs Virus	Yes No	20. Cleft lip/palate	Yes No	31. Cancer, tumors, growths or cysts	Yes No
10. Herpes virus/shingles	Yes No	21. Scarlet Fever	Yes No	32. Sinus Problems/Drainage	Yes No
11. Diabetes	Yes No	22. High/Low Blood Pressure	Yes No	33. Tuberculosis or TB exposure	Yes No
12. Ear, eye, nose, throat issues	Yes No	23. Liver Disease	Yes No	34. Problems with Anesthesia	Yes No
13. Stomach Ulcers	Yes No	24. Jaundice or Hepatitis	Yes No	35. Thyroid Problems	Yes No

Current Medications:

Name/Strength (mg)	How often?	Reason Taken
________________________	________________________	_______________________
________________________	________________________	_______________________
________________________	________________________	_______________________

Social History:

Does your child have problems with any of the following? SPEECH HEARING VISION SLEEP

Do you consider your child to be? Advanced in learning Progressing normal A slow learner

Child's first language_____________________ Child's second language_____________________

Is your child adopted? YES NO If yes, at what age? __________________________________

How does your child tolerate dental/medical care? ______________________________________

Child's favorite (pet, toy, color, friend, hobby, etc.) ______________________________________

AUTHORIZATION AND RELEASE:

I understand that payment of a calculated % is due at the time treatment is rendered, and that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of my dependents(s), including any balance not paid by the dental insurance company within 30 days of the date of service. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to the dentist group any insurance benefits otherwise payable to me.

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to my child during period of such dental care to third party payers' and/or health practitioners.

Signature of Parent/Guardian ____

Printed Name____ Date: ___________________________