PATIENT INFORMATION

Child's Name: _____
Last First Middle Preferred

( ) Male ( ) Female Date of Birth: _____ Hobbies/Interests: _____

Address: _____ City/State: _____ Zip: _____

SSN: _____ Home phone: _____ Cell: _____

Email address: _____ How would you prefer us to contact you for confirming your child's appointments?
( ) Phone ( ) Email ( ) Text ( ) All

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

PARENT INFORMATION

( ) Mother ( ) Stepmother ( ) Guardian Name: _____

Address (if different from above): _____ Work Phone: _____

Phone (if different from above): _____ Employer: _____

( ) Father ( ) Stepfather ( ) Guardian Name: _____

Address (if different from above): _____ Work Phone: _____

Phone (if different from above): _____ Employer: _____

DENTAL INSURANCE

Policy Holder: _____ Relationship to Patient: _____

Insurance Co.: _____ Policy Holder Social Security #: _____ Date of Birth: _____

Policy #: _____ Group #: _____ ID #: _____

MEDICAL HISTORY

Child's Pediatrician: _____ City/State: _____

Name of Practice: _____ Date of last physical exam: _____

Were there any difficulties during the pregnancy or delivery of your child? ( ) Yes ( ) No If yes, please describe: _____

_____

_____

MEDICATIONS

Please list any medications your child is taking and the correlating diagnosis: _____

_____

ALLERGIES

( ) Penicillin/Amoxicillin ( ) Latex ( ) Aspirin ( ) Sulfa ( ) Local Anesthetic

( ) Foods: list _____ ( ) Other _____

Does your child have any history of the following medical concerns? *Check all that apply*

General Conditions

___Arthritis
___Asthma
___Diabetes
___GI Disorder
___GERD/Reflux
___Hearth Disease
___Heart Murmur
___Kidney Disease
___Rheumatic Fever

Behavioral/Learning

___ADD/ADHD
___Anxious/Nervous
___Autism
___Asperger Syndrome
___Behavioral Issues
___Learning Disability
___Psychiatric Disorder

Developmental

___Blindness
___Visual Impairment
___Brain Injury
___Cerebral Palsy
___Cleft Lip/Palate
___Developmental Delay
___Down Syndrome
___Eating Problems
___Growth Problems
___Hearing Loss/Deaf
___Neuromuscular Defect
___Orthopedic Problem
___Seizures
___Speech Delay
___Spina Bifida

Hematological (Blood)

___Anemia
___Bleeding issues
___Hemophilia
___Sickle Cell Trait
___Sickle Cell Disease
___Blood Transfusion

Infectious

___Hepatitis
___HIV
___AIDS
___Tuberculosis

Other

___Adenoids
___Allergies (seasonal)
___Cancer/Tumors
___Fainting
___Headaches
___Leukemia
___Skin Disorder
___Sleep Apnea
___Snoring
___Thyroid Disorder
___Tonsils
___Tubes in ears
___Other, please specify

_____

_____

Have you ever been told your child requires antibiotic prophylaxis for dental treatment due to a medical condition (e.g., heart condition, shunt, etc.)?

( ) Yes ( ) No

Physician following condition?_____ Phone Number: _____

DENTAL HISTORY

Previous Dentist: _____ Last Visit: _____

My child brushes his/her teeth _____ times/day

Does he/she floss every day? ( ) Yes ( ) No

Do you help your child brush? ( ) Yes ( ) No

Is fluoride taken in any form? ( ) Yes ( ) No

Any history of bad dental experiences? ( ) Yes ( ) No

Any current dental plan? ( ) Yes ( ) No

Any injuries to the mouth or teeth? ( ) Yes ( ) No

Please describe: _____

Does your child have any of the following habits?

( ) Thumb/finger sucking ( ) Grinding teeth during sleep ( ) Pacifier use

( ) Sleeping with bottle/sippy cup ( ) Mouth breathing ( ) Snoring

Is there anything else you would like us to know regarding your child's dental health? _____

AUTHORIZATION TO BRING MINOR FOR DENTAL TREATMENT

List anyone who may accompany your child (please specify the relationship) to an appointment and has permission to make decisions concerning his/her dental treatment: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. 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 medical status.

SIGNATURE OF PARENT OR LEGAL GUARDIAN:_____ DATE:_____