



Tell Us About Your Child

Today's Date: ___/___/___ Preferred Name: _____

Child's Name: _____
LAST FIRST MI

Birthdate: ___/___/___ Age: _____ Male Female

Address: _____

CITY STATE ZIP

Home Phone: _____

Cell Phone: _____

Email: _____

General Information

Who is accompanying child today?

Do you have legal custody of this child? Y / N

Whom may we thank for referring you?

Other siblings/ages: _____

Hobbies: _____

Parents' Information

Father **Stepfather** **Guardian**

Mother **Stepmother** **Guardian**

Marital Status: S M D W Birthdate: ___/___/___

Marital Status: S M D W Birthdate: ___/___/___

Name: _____

Name: _____

Address: (If different than child's)

Address: (If different than child's)

Home Phone: _____ Cell: _____

Home Phone: _____ Cell: _____

Work Phone: _____ SSN: _____

Work Phone: _____ SSN: _____

Employer: _____

Employer: _____

Email: _____

Email: _____

PRIMARY DENTAL INSURANCE

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Name: _____

Insured's ID #: _____ Group #: _____

Insured's ID #: _____ Group #: _____

Ins. Phone: _____

Ins. Phone: _____

Driver's License: _____ SS#: _____

Driver's License: _____ SS#: _____

Dental and Medical History

Has your child been to a dentist before? Y / N Previous General Dentist: _____

Last Dental Visit: _____ What are the main concerns?: _____

Is your child currently in pain? Y / N Please specify: _____ Any pain in the jaw joint? Y / N

Has your child experienced any unfavorable reaction from any previous dental care? Y / N Please specify: _____

Please rate your child's oral health: Good / Fair / Poor Does your child brush his/her teeth daily? Y / N

Does your child require antibiotics before dental procedures? Y / N If yes, please specify reason: _____

Are you currently under a physician's care? Y / N If yes, explain: _____

Family Physician: _____ Phone: _____

Address: _____

Date of last visit to physician: ___ / ___ / ___ Please rate your child's mental health: Good Fair Poor

Are you taking any medicine at this time? Y / N Please specify: _____

Are you allergic to any medications? Y / N Please specify: _____

Are you allergic to the following medications?

Yes / No Penicillin Yes / No Tetracycline Yes / No Erythromycin Yes / No Aspirin Yes / No Dental Anesthetics Yes / No Codeine Yes / No Sulfa

Do you have any known allergies (latex, nickel, nuts, etc.)? Y / N Please specify: _____

Have you been hospitalized or had any surgeries? Y / N Please specify: _____

Do you have any history of these?:

Yes / No Heart attack / Stroke

Yes / No Sinus Problems

Yes / No Heart Disorder/Murmur/Defects

Yes / No Hepatitis or Liver Disorder

Yes / No Anemia / Bleeding Disorders

Yes / No Difficulty Breathing

Yes / No Artificial valves

Yes / No Kidney or Bladder Disorder

Yes / No Prolonged Bleeding/Clotting Disorder

Yes / No Asthma

Yes / No Hypertension

Yes / No Ulcers / Colitis

Yes / No Bone Problem or Disorder

Yes / No Bronchitis

Yes / No Congenital Heart Disease

Yes / No Pacemaker

Yes / No Arthritis/Joint Swelling

Yes / No Tuberculosis

Yes / No Heart Surgery

Yes / No Emotional Disorders

Yes / No Artificial Joints

Yes / No Neurologic Disorder

Yes / No Rheumatic Fever

Yes / No Hearing difficulties

Yes / No AIDS or HIV

Yes / No Cerebral Palsy

Yes / No Mitral Valve Prolapse

Yes / No Daily Aspirin/Blood Thinner

Yes / No Cancer / Chemotherapy / Radiation

Yes / No Convulsions/Seizures

Yes / No Endocrine/Hormone Disorders

Yes / No Pregnant (For women)

Yes / No Hearing Impairment

Yes / No Headaches

Yes / No Diabetes

_____ **Doctor's Initials**

If you are experiencing or have a history of any disease, condition, or problem not addressed, please explain:

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 also authorize the dental staff to perform the necessary dental services that my child may need.

The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Signature of parent or guardian : _____ Date: _____