PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your child's dental health.

Patient name_____ Preferred name_____

Birth date: ___/___/_____ School_____ Grade _____

Reason for visit_____ Male/Female

Parent/ Guardian Information

Name_____ Birth date: ___/___/_____

Home Address_____ Apt. #_____

City_____ State_____ Zip_____

Home Phone (_____) _____-_____ Cell Phone (____)_____-_____

E-Mail _____ Relationship to child_____

Employer_____ Occupation_____

Parent/ Guardian Information

Name_____ Birth date: ___/___/_____

Home Phone (_____) _____-_____ Cell Phone (____)_____-_____

E-Mail _____ Relationship to child_____

Employer_____ Occupation_____

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

☐ Internet/Website ☐ Flyer/ Mail ☐ Dentist ☐ Physician ☐ Other

Primary Carrier

Insurance Co. _____

Ins. Phone#: _____

Policy holder: _____

DOB: ____/____/_____

ID#/SSN: _____

Group # _____

Secondary Carrier

Insurance Co. _____

Ins. Phone#:_____

Policy holder: _____

DOB: ____/____/_____

ID#/SSN: _____

Group # _____

Patients Name_____ **Date of Birth**___/___/_____

Dental History

Is this your child's first dental visit? ☐ Yes ☐ No

How often does your child brush? _____

Previous dentist _____ City _____State _____

Date of last visit _____

How do you think your child will react towards the dentist? _____

_____

Has your child had any negative experiences at the dentist before? _____

_____

Does your child do any of the following? (Please check any that apply)

- ☐ Brushes with fluoridated toothpaste
- ☐ Takes fluoride supplements
- ☐ Brushes with help from an adult
- ☐ Uses dental floss
- ☐ Eats or drinks after brushing at night
- ☐ Drinks only bottled water
- ☐ Drinks Juice
- ☐ Drinks sports drinks
- ☐ Child falls asleep with milk or juice
- ☐ Child uses a bottle with milk or juice
- ☐ Child uses a sippy cup
- ☐ Nursing during the day
- ☐ Nursing to sleep
- ☐ Chewing objects
- ☐ Nail biting
- ☐ Grinding
- ☐ Thumb sucking
- ☐ Lip sucking
- ☐ Finger sucking
- ☐ Pacifier
- ☐ Mouth breather
- ☐ Snores
- ☐ Injury to child's teeth (falls, chips)

Patient's Name_____

MEDICAL HEALTH HISTORY

Does your child have or has your child had any of the following?

(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Blood transfusion; Date of last transfusion _____
- ❑ Diabetes
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Fractured Jaw
- ❑ Anemia or blood disorders
- ❑ Hay Fever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Autism
- ❑ ADHD/ADD
- ❑ Premature Birth
- ❑ Hearing Problems
- ❑ Intellectual Disability
- ❑ Congenital Birth Defects
- ❑ Speech Problems
- ❑ Behavioral Problems
- ❑ Pregnancy
- ❑ Radiation Treatment
- ❑ Autoimmune System Problems

Is your child allergic to, or has your child reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Name of child's physician _____Phone Number_____

Is your child taking any medication? What?_____

Has your child ever been hospitalized or had surgery? For what?_____

Is your child allergic to any food or medicine? What? _____

Does your child have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about_____

_____

Signature of Parent or Guardian _____ Date _____