Welcome! **We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.**

Patient Information

Date: ______________________

Child's Name ____ Male or Female

Age________ Date of Birth_______________ Preferred Name ________________ School ________________

Home Address ____ Phone ________________

Street City State Zip

Whom may we thank for referring you? ____

Parent Information

Father's Name _______________________ Soc.Sec #___________________ Date of Birth _______________

Address ____ Phone _________________

(if different from patient's) Street City State Zip (if different from patient's)

Father's Occupation ______________________________ Employer __________________________________

Work Phone _______________ Cell Phone __________________ Drivers License # ______________________

Mother's Name ______________________ Soc.Sec #____________________ Date of Birth ______________

Address ____ Phone _________________

(if different from patient's) Street City State Zip (if different from patient's)

Mother's Occupation _____________________________ Employer __________________________________

Work Phone _______________ Cell Phone __________________ Drivers License # ______________________

Email Address: ____

How would you like us to confirm your appointment? Home Cell Text Email

Person responsible for Account ____

Is your child covered by your dental insurance plan? Yes No

Primary Dental Insurance

Insurance Co. Name ______________________________ Insurance Co. Phone _________________________

Insurance Co. Address _____________________________ Policy Holder ______________________________

Member ID number ____________________________

The medical and dental history questions provide us with important information to evaluate, diagnose and treat your child. Please answer all the questions. If there are any questions that you do not understand, please ask us for help. We will be happy to assist you. All information is held in the strictest confidence. Thank you for taking the time in this regard, it helps us to provide superior care.

Medical History

Child's Physician ______________________________ Phone _____________________ Date of last exam _______________

Is your child presently under medical care? Yes No If yes, explain ____

Is your child currently taking medications? Yes No Reason ____

Please list all medications ____

Does your child have allergies or reactions? Yes No Allergic to ____
(medications, drugs, foods, anything)

Has your child ever been hospitalized? Yes No Reason __________________________________ Date ____________

Has your child ever had surgery
under general anesthesia? Yes No Reason __________________________________ Date ____________

Has your child ever had a blood transfusion? Yes No Date _______________

Has your child ever had any of the following medical problems?

Yes	No	Heart Disease	Yes	No	Liver Problems	Yes	No	Cancer
Yes	No	Heart Murmur	Yes	No	Kidney Problems	Yes	No	Tuberculosis
Yes	No	Congenital Heart Defect	Yes	No	HIV+/AIDS	Yes	No	Bone Problems
Yes	No	Rheumatic Fever	Yes	No	Epilepsy	Yes	No	Asthma
Yes	No	Bleeding Disorder	Yes	No	Diabetes	Yes	No	Hearing Loss
Yes	No	Hemophilia	Yes	No	Hepatitis	Yes	No	Vision Loss

Other Medical Conditions ____

Characterize your child's mental development: Normal 1-2 years behind More than 2 years behind

Dental History

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

Has your child ever been to the dentist? Yes No Date of last dental visit ________________________________

Characterize your child's past dental experiences: ____

Briefly describe your child's oral hygiene routine: ____

Does your child have a finger, thumb or pacifier habit? Yes No

Does your child's jaw make noise or is there pain associated with jaw movement? Yes No

Briefly describe any past dental trauma: ____ Date _______________

Circle all water sources your child uses: Tap tap/filtered well bottled bottled with fluoride

Has your child ever taken fluoride supplements? Yes No

I understand the information given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical condition.

Signature of parent or guardian ____ Date _________________________