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CHILD PATIENT INFORMATION

Today's date:_____

Child's name:_____ Birthdate:_____ Age:_____ Sex:_____
LAST FIRST MI

Child's Nickname:_____ School:_____ Grade:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

SS#:_____

Home Phone #:_____ Mom's Cell Phone #:_____ Dad's Cell Phone #:_____

Please circle best number to confirm appointments.

Mom's name:_____ Occupation:_____ □ Full Time □ Part Time

Address (If different from Child's):_____ City:_____ State:____ Zip:_____

Dad's name:_____ Occupation:_____ □ Full Time □ Part Time

Address (If different from Child's):_____ City:_____ State:____ Zip:_____

Parent's Relationship: □ Married □ Separated □ Divorced □ Never together □ Widowed
□ Single Parent □ Guardian □ Foster Parent □ Other:_____

How many siblings?_____ Age(s): _____ _____ _____ _____

Primary dental insurance:_____ Group #:_____

Subscriber's name:_____ Date of birth:_____ SS#:_____

Secondary dental insurance:_____ Group #:_____

Subscriber's name:_____ Date of birth:_____ SS#:_____

EMERGENCY CONTACT Name:_____ Phone #:_____ Relation:_____

Child's medical doctor or clinic:_____ Date of last visit to medical doctor:_____

Name of previous dentist:_____ Date of last visit to dentist:_____

Whom can we thank for referring you?:_____

DENTAL HEALTH HISTORY

Has there been any difficulty with dental treatment in the past?_____ If yes, please explain:_____

_____

Has there been any injuries to your child's head/mouth/teeth?_____

Has your child ever sucked their thumb or finger(s)? **YES** (currently) **YES** (previously) **NO**
If yes, what age?_____ **Additional explanation:**_____

Does your child have any speech problems? **YES** (currently) **YES** (previously) **NO**
If yes, explain:_____

Has either parent had ortho treatment?..... **YES** **NO**
Any siblings that have had ortho treatment?..... **YES** **NO**
Do you notice your child grinding his/her teeth?.. **YES** **NO**
Does your child brush his/her own teeth? ..... **YES** **NO** .....How many times a day? ____
Do you assist brushing his/her teeth? ..... **YES** **NO** .....How often? ____
Or, do you exclusively brush his/her teeth?..... **YES** **NO** .....How often? ____
Is dental floss used?..... **YES** **NO** .....How often? ____
Do you have well water? ..... **YES** **NO** .....Is your child using Fluoride Supplements? .....**YES** **NO**

MEDICAL HEALTH HISTORY

Does your child have, or has he/she had, any of the following?

	YES	NO
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
High/low blood pressure	☐	☐
Heart murmur	☐	☐
Artificial heart valve	☐	☐
Rheumatic fever	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Leukemia	☐	☐
Ever have blood transfusion?	☐	☐
Allergy Problems	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Asthma	☐	☐
Persistant cough or swollen glands	☐	☐
Chronic Ear Infections	☐	☐

	YES	NO
Tuberculosis or Respiratory disease	☐	☐
Intestinal Problems	☐	☐
Ulcers or acid reflux	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Joint replacement	☐	☐
Fainting spells, seizures	☐	☐
ADD/ADHD	☐	☐
Epilepsy or neurological disease	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
History of head injury?	☐	☐
Diabetes	☐	☐
Check blood sugar daily	☐	☐
Family history of diabetes	☐	☐
Thyroid problems	☐	☐
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV+ or AIDS	☐	☐
Cancer/Tumor	☐	☐

	YES	NO
Play musical Instrument?	☐	☐

If yes, what instrument?

_____

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

_____

_____

_____

_____

Has your child had any of the following operations? If yes, fill in the year of surgery.

	Year
Tonsils removed	_____
Adenoids removed	_____
Tubes placed in ears	_____

ALLERGIES

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

	YES	NO
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Latex	☐	☐

Other:_____

_____

MEDICATIONS

	YES	NO	DON'T KNOW
Premedication required by physician?	☐	☐	☐

What prescription medications is your child currently taking?

_____

_____

_____

_____

_____

Vitamin/Supplements/Natural Remedies:

_____

∞ We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

∞ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.

∞ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

∞ I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes to the information I have provided

Patient/Guardian Signature :_____Date:_____

UPDATE (OFFICE USE)

	Initial	Date
1.	_____ /	_____
2.	_____ /	_____
3.	_____ /	_____
4.	_____ /	_____
5.	_____ /	_____
6.	_____ /	_____