

PATIENT CHILD INFORMATION

Patient's Name _____ Nickname _____ Today's Date _____
 Social Security # _____ - _____ - _____ Date of Birth ____/____/____ Age _____ Weight _____
 Home Address _____ City _____ State _____ Zip _____
 Brothers/Sisters Names/Ages _____ Res. Tel.# _____
 Father's Name _____ Social Security # _____ - _____ - _____
 Home Address _____ Tel # _____ DOB _____
 Father's Occupation _____ Employer _____ Bus.Tel# _____
 Mother's Name _____ Social Security # _____ - _____ - _____
 Home Address _____ Tel# _____ DOB _____
 Mother's Occupation _____ Employer _____ Bus.Tel# _____
 Guardian if Different _____ Social Security # _____ - _____ - _____
 Home Address _____ Tel# _____
PERSON TO CONTACT IN AN EMERGENCY _____ Relation _____
 Res. Tel. # _____ Bus. Tel. # _____
 Reason for this visit _____
 Whom may we thank for referring you? _____
 Child's Favorite Pet, Toy, or Hobby. _____

INSURANCE INFORMATION

Insured _____ Insured's SS # _____ - _____ - _____ Insured's DOB ____ - ____ - ____
 Insurance Co. _____ Insurance Co. Tel _____ Group # _____

HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating your child, please carefully review this form completely and fill out all areas which pertain to your child.

ALL THIS INFORMATION IS CONFIDENTIAL

Dental History:

Previous Dentist _____ City _____ How long _____
 Date of last visit _____ Date of last dental cleaning _____ Date of last full mouth x-ray _____

Medical Health History:

- | | | | | |
|---|-----------|------|------|------|
| 1. Describe your child's present health | Excellent | Good | Fair | Poor |
|---|-----------|------|------|------|
2. List your child's current Physician(s): a. _____ Phone _____
 b. _____ Phone _____
3. Date of your child's last physical exam ____/____/____ Purpose _____
4. Are you aware of any changes in your child's general health in the last year? No Yes _____
5. Has your child been hospitalized for illness or surgery? No Yes _____
6. Has your child ever had excessive bleeding that required special treatment? No Yes _____
7. Is there any history of diabetes in your family? No Yes _____
8. Is your child on a special or restricted diet of any kind? No Yes _____
9. List all medications your child is now taking (include over the counter) _____

 List all medications your child is allergic to: _____
10. Does your child have a history of nail biting, thumb or finger sucking, mouth breathing, teeth grinding?
 No Yes _____
11. Does your child have or had frequent ear and throat infection or tubes in ears? No Yes _____
12. Does your child have a history of hearing loss or speech problems? No Yes _____

13. Has the mother and father experienced a lot of tooth decay? No Yes _____
14. In your family is there any history of malocclusions, bad bites, missing or extra teeth? No Yes _____
15. Has your child had a tooth ache recently? No Yes _____
16. Is your child in pain now? No Yes _____
17. Do you think there is anything wrong with his/her teeth, such as a chipped or decayed tooth, gum boil, etc? No Yes _____
 Explain _____
18. Has your child had previous dental treatment? No Yes _____
 When and where? _____
19. Does the mother and father and child live together? If no please explain. No Yes _____
20. Is your child adopted? No Yes _____
21. Who is responsible for tooth cleaning? _____ Parent _____ Child _____ Both

Indicate which of the following your child has had or presently has:

Heart Disorders	No/Yes	Blood Disorders	No/Yes	Cancers or Tumors	No/Yes
Bladder Disorder	No/Yes	Kidney Disorders	No/Yes	Radiation Treatment	No/Yes
Bleeding Disorders	No/Yes	Thyroid Disorders	No/Yes	Chemotherapy	No/Yes
Cerebral Palsy	No/Yes	Chicken Pox	No/Yes	Hearing Disorders	No/Yes
Lung Disorders	No/Yes	Malignancies	No/Yes	Measles	No/Yes
Heart Murmur	No/Yes	Tuberculosis	No/Yes	Mental Retardation	No/Yes
Rheumatic Fever	No/Yes	Asthma	No/Yes	Hepatitis	No/Yes
Mononucleosis	No/Yes	Mumps	No/Yes	Liver Disease	No/Yes
Vision Disorders	No/Yes	Sinus Trouble	No/Yes	Blood Transfusions	No/Yes
Allergies or Hives	No/Yes	AIDS	No/Yes	Diabetes	No/Yes
HIV+	No/Yes	Hemophilia	No/Yes	Epilepsy or Seizures	No/Yes
Anemia	No/Yes				

If Female, is your child Pregnant? No/Yes Birth Control Pills No/Yes

Does your child have any medical conditions or diseases we should know about? No/Yes
 Explain: _____

Because your child is a minor it is necessary that signed permission be obtained from a parent or guardian on all necessary dental treatment. The undersigned also agrees to be responsible for any bill incurred on this child for dental treatment. To the best of my knowledge, all the preceding answers are true and correct. If my child has any changes in his/her health or medicines, I will inform the Doctor on or before their next appointment, without fail.

Parent's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____