Patient Information

Child's Name: _____ Date: _____
Last, First MI Nickname

Birth Date: _____ Age: _____Gender: _____

Name of School_____ Grade _____Hobbies_____

Names and Ages of Siblings_____

Father's Name_____ Mother's Name_____

Parent's Marital Status: Married_____ Single_____ Widowed_____ Separated_____ Divorced_____

Phone (Home): _____ Mom's Cell _____ Dad's Cell_____

Address: _____
Street Apartment #

_____
City State Zip Code

Father's Information **Mother's Information**

_____**Employer & Occupation**_____

_____**Business Address**_____

_____**Business Phone**_____

_____**Email**_____

_____**Social Sec No.**_____

_____**Birth Date**_____

_____**Name of Insurance Carrier**_____

_____ **Address of Insurance Carrier**_____

_____**Policy ID Number**_____

_____**Group No**_____

Health Information

Child's Physician _____ Address: _____ Phone_____

Has your child ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Palate
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Sight Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

OTHER:

☐ _____

- Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____

- Is child receiving any medications or drugs? What?_____

IS YOUR CHILD ALLERGIC TO: Please answer "YES" or "NO" for each

Penicillin_____Antibiotics_____Local Anesthetic (Lidocaine)_____

Aspirin_____Foods_____Latex_____Other Medications (including over the counter)_____

DENTAL HISTORY : PLEASE REVIEW ALL QUESTIONS

Name of previous dentist_____Address_____Phone_____

Date of last dental visit_____For what service?_____

Date of last x-rays taken_____ Reason for visit today_____

Has child complained about dental problems?_____If yes, explain_____

Any unhappy dental experiences?_____If yes, explain_____

Any injuries to mouth, teeth, or head?_____If yes, explain_____

Any mouth habits, thumbsucking, finger sucking, mouth breathing, nursing bottle habits, pacifier (Circle)

Any unusual speech habits?_____

Any Orthodontic appliances worn now or ever?___If yes, explain_____
Name of Orthodontist_____Address/Phone_____

Does your child brush teeth daily? _____

Do you assist child with tooth brushing? _____

Is fluoride taken in any form – How?_____

To the best of my knowledge, all of the above answers and information provided are true and correct. If there are ever any change in my child's health, I will inform the staff at the next appointment without fail.

_____ Date: _____
Signature of parent or guardian

Emergency Contact: Name (other than parent)_____ Phone Number: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Drive by, Sign ☐Yellow Pages ☐ Website

☐ Newspaper ☐ School ☐ Work ☐ Dental Office ☐ Other _____

Name of person or office referring you to our practice: _____

Consent for Services

Since this patient is a minor, it becomes necessary that a signed permission be obtained from the parent or guardian before any dental service can be performed. Authorization is herby granted as such. Furthermore, I will be responsible financially for any bill incurred on the patient for dental treatment or, if I indicated someone else is responsible, permission is granted for verification.

_____ Date: _____ Relationship to patient_____
Signature of parent or guardian