Today's Date _____

PATIENT INFORMATION AND HEALTH HISTORY

We are pleased to welcome you and your child to our practice. Please fill out this form completely in ink.

YOUR CHILD

Child's Name:_____ Nickname:_____ SSN:_____

Address:_____ City/State/Zip:_____

Home Phone:( )_____ Age:_____ Birth Date:_____ Gender: Male or Female

Names of brothers or sisters who are patients_____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Person financially responsible:_____ Relationship:_____

Who is responsible for making appointments? _____

PARENT OR GUARDIAN INFORMATION: ☐ MOTHER ☐ STEPMOTHER ☐ GUARDIAN

Name:_____ Email:_____

Address: _____ City/State/Zip:_____

Birth date:_____ Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

Employer:_____ SSN:_____ DL#:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

PARENT OR GUARDIAN INFORMATION: ☐ FATHER ☐ STEPFATHER ☐ GUARDIAN

Name:_____ Email:_____

Address: _____ City/State/Zip:_____

Birth date:_____ Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

Employer:_____ SSN:_____ DL#:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

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PRIMARY DENTAL INSURANCE

Insurance Co._____ Phone #_____ Group # or ID #:_____

Insured's Name _____ Relationship to patient:_____

Birth date:_____ SSN:_____ Employer:_____

SECONDARY DENTAL INSURANCE OR MEDICAL INSURANCE

Insurance Co._____ Phone #_____ Group # or ID #:_____

Insured's Name _____ Relationship to patient:_____

Birth date:_____ SSN:_____ Employer:_____

Does your child have any hobbies or special interests?_____

Is there any information which would allow us to better care for your child?_____

_____

DENTAL HISTORY

Date of last dental visit _____ Purpose of today's visit _____

How often does your child: brush _____ floss _____ Does an adult brush or floss for your child? _____

What is the primary source of your drinking water supply: ☐ City ☐ Bottled water ☐ Home Well ☐ Don't know

Does your child take fluoride supplements? _____ Have there been any injuries to the teeth or jaws? _____

Any habits: thumb sucking, pacifier, bottle, etc? _____

Any unhappy dental or medical experiences? _____

MEDICAL HISTORY

Child's physician: _____ Address: _____ Phone: _____

Date of last physical exam: _____ Results: _____

Is your child being treated for any medical conditions? _____ Please Explain. _____

Is your child taking any medications? _____ Please Explain. _____

Has your child had any hospitalizations, serious illness or surgeries? _____ Please Explain. _____

Is your child allergic to any medications? _____

DOES YOUR CHILD HAVE A HISTORY OF THE FOLLOWING CONDITIONS?

☐ **There is no history of any of the problems below.**

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	Hepatitis	☐	☐	Hearing Problems
☐	☐	Heart Problems	☐	☐	Diabetes	☐	☐	Speech Problems
☐	☐	Heart murmur	☐	☐	Tuberculosis	☐	☐	Emotional Difficulties
☐	☐	Sickle cell anemia	☐	☐	Kidney Disease	☐	☐	Mental Disorder
☐	☐	Bleeding problems	☐	☐	Skin Problems	☐	☐	Fainting or dizziness
☐	☐	Birth Defects	☐	☐	Anemia	☐	☐	Poor vision
☐	☐	Epilepsy or seizures	☐	☐	Cerebral Palsy	☐	☐	Bone / joint problems
☐	☐	Asthma / wheezing	☐	☐	Nose problems	☐	☐	Ear problems
☐	☐	Throat problems	☐	☐	HIV/AIDS	☐	☐	Latex Allergy
☐	☐	Abnormal number/color of teeth	☐	☐	Cancer	☐	☐	Allergies
☐	☐	Autism	☐	☐	Penicillin Allergy	☐	☐	Codeine Allergy
☐	☐	Other: _____						

AUTHORIZATION:

To the best of my knowledge, the questions on this form have been answered accurately. I understand that the answers I have provided will be used by the dentist to determine the appropriate dental treatment for my child. It is my responsibility to inform the dental office of any changes in my child's medical status. ☒ I authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. ☒ I agree to be responsible for payment of all services rendered on behalf of my dependents.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

FOR OFFICE USE ONLY

MOLARS: Right _____ **Left** _____ **OB:** _____ **%** **OJ:** _____ **mm**

MIDLINE: _____ **CROWDING:** _____ **CROSSBITE:** _____ **wt:** _____