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:______________________________ Preferred:________________ Birth Date:________________

Address:______________________________ City/State/Zip:______________________________

SSN:____________________ Age:____________ Gender: Male or Female

Names of siblings who are our patients.______________________________

Whom may we thank for referring you? ______________________________

RESPONSIBLE PARTY: ☐ MOTHER ☐ FATHER ☐ STEPMOTHER/FATHER ☐ GUARDIAN

Name:______________________________ Email:______________________________

Address: ______________________________City/State/Zip:______________________________

Birth date: ____________ Cell Phone: (_____)________________ Employer/Number:______________________________

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

☐ **FINANCIALLY RESPONSIBLE** ☐ **RESPONSIBLE FOR MAKING APPOINTMENTS**

OTHER PARENT OR GUARDIAN INFORMATION: ☐ MOTHER ☐ FATHER ☐ STEPMOTHER/FATHER ☐ GUARDIAN

Name:______________________________ Email:______________________________

Address: ______________________________City/State/Zip:______________________________

Birth date: ____________ Cell Phone: (_____)________________ Employer/Number:______________________________

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

☐ **FINANCIALLY RESPONSIBLE** ☐ **RESPONSIBLE FOR MAKING APPOINTMENTS**

EMERGENCY CONTACT: Name: ______________________________ Cell Phone: (______)____________________

Relationship: ________________________

PRIMARY DENTAL INSURANCE

Insurance Co.________________________ Phone #________________ Group # or ID #:________________

Policy Holder ______________________________ Relationship to patient:________________

Birth date:________________ SSN:________________________ Employer:________________________

SECONDARY DENTAL INSURANCE OR MEDICAL INSURANCE

Insurance Co.________________________ Phone #________________ Group # or ID #:________________

Policy 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:_______________________________						

MOLARS: Right_________ **Left**___________ **OB:**_______**%**___ **OJ:**_______**mm**___

MIDLINE:______ **CROWDING:**_______________ **CROSSBITE:**_______________ **wt:**_________

X-rays Taken: Yes or No

X-ray Type and Tooth Number: ________________________________

Treatment Needed: ______________________________________

Next Visit: ____

Cleaned By: ____

Scribed By: ____

Examined By: ____