Patient Information

Today's Date: _____

Name of Child/Minor: _____ Sex: ☐ Male ☐ Female
Last Name First Name Middle Initial

Child prefers to be called: _____

Age: _____ Date of Birth: _____ Child's Social Security Number: _____

Address: _____ City: _____ State: _____ Zip _____

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

Home Phone: _____ Child's Hobbies: _____

If Student, Name of School Attending: _____ City/State: _____

Is the child adopted? ☐ Yes ☐ No If "Yes", date of adoption: _____

Is the child in a foster home? ☐ Yes ☐ No If "Yes", name of foster parents: _____

Whom may we thank for referring you? _____

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of the child? ☐ Yes ☐ No If "No", please indicate the following regarding the individual who has custody:

Name: _____ Relation: _____

Phone: _____ Address: _____
Street City State Zip

Parent's Information

Mother's Name: _____ ☐ Mother ☐ Stepmother ☐ Guardian

Date of Birth: _____ Social Security Number: _____

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

Address if different than patients: _____
Street City State Zip

Home Phone: _____ Cellular Phone: _____

E-Mail Address: _____

Employer: _____ Work Phone: _____ May we call you at work? ☐ Yes ☐ No

Father's Name: _____ ☐ Father ☐ Stepfather ☐ Guardian

Date of Birth: _____ Social Security Number: _____

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

Address if different than patients: _____
Street City State Zip

Home Phone: _____ Cellular Phone: _____

E-Mail Address: _____

Employer: _____ Work Phone: _____ May we call you at work? ☐ Yes ☐ No

Insurance Information

Primary Insurance

Have you used your insurance at any other dental office this year? ☐ Yes ☐ No

Insurance Company: _____ Phone Number: _____

Policy Holder: _____ DOB: _____ Social Security Number: _____

Employer: _____ ID #: _____ Group #: _____

Secondary Insurance

Insurance Company: _____ Phone Number: _____

Policy Holder: _____ DOB: _____ Social Security Number: _____

Employer: _____ ID #: _____ Group #: _____

MEDICAL / DENTAL HISTORY

General health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Date of last physical: _____

Name and address of Physician: _____

Are you taking any prescription, over-the-counter or herbal medications? ☐ Yes (list below) ☐ No

_____

_____

Describe any current medical treatment, including drugs and impending operations:

_____

There are many medical situations which can affect or be affected by the procedures or drugs used for dentistry. Therefore, please fill out the following carefully.

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING: - INDICATE WITH (X)

☐ Heart disease	☐ Herpes Simplex I, II or HPV	☐ Osteoporosis/Osteopenia
☐ Heart valve replacement	☐ Kidney problems	☐ Stroke/CVA
☐ Abnormal blood pressure	☐ Glaucoma	☐ AIDS/HIV
☐ High cholesterol	☐ Artificial joints	☐ Autoimmune disorders
☐ Ulcers	☐ Do you take a blood thinner?	☐ COPD/Emphysema
☐ colitis	☐ Thyroid problems	☐ GERD
☐ Tuberculosis	☐ Heart murmur	☐ Arthritis
☐ Diabetes – Type 1 ☐ Type 2 ☐	☐ Asthma	☐ Serious accident
☐ Epilepsy	☐ Hepatitis Type ____	☐ Cancer
☐ Congenital heart defects	☐ Liver problems	☐ Anemia
☐ Persistent cough	☐ Eye disorders	**Blood Pressure _____**

Have you ever been treated with chemo or radiation therapy? ☐ Yes ☐ No

List allergies to latex, foods and medications:

_____

Are you subject to excessive bleeding from cuts or extractions? ☐ Yes ☐ No

Are you subject to fainting or dizzy spells? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No – If so, when are you expecting _____

Name of doctor _____ Are you taking birth control? ☐ Yes ☐ No

Date of last dental exam _____ Any previous major dental treatment? ☐ Yes ☐ No When?_____

Do you have or have you had any of the following?

☐ Pain around ear	☐ Difficulty opening widely	☐ Orthodontic treatment
☐ Unusual sounds in ear while eating	☐ Unfavorable dental experience	☐ Mouth breathing
☐ Frequent headaches	☐ Complications from extractions	☐ Gum disease/treatment
☐ Sleep apnea/CPAP	☐ Burning tongue	

Have you noticed any of the following signs of gum disease?

☐ Bleeding gums during toothbrushing	☐ Pus between the teeth and gums
☐ Red, swollen or tender gums	☐ Loose or separating teeth
☐ Gums that have pulled away from the teeth	☐ Change in the way your teeth fit together
☐ Persistent bad breath	☐ Food catching between teeth

Is it important to keep your teeth for as long as possible? ☐ Yes ☐ No

If you have missing teeth, why have you not had them replaced? _____

Do you like the appearance of your smile? ☐ Yes ☐ No Do you brush daily? _____ Times/Day

Do you like the color of your teeth? ☐ Yes ☐ No Do you floss daily? _____Times/Day

Do your teeth keep you from eating any specific food? ☐ Yes ☐ No

I hereby verify that the above information is true and correct.

_____

Patient/Legal Guardian Signature **Date**