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 #: _____

PATIENT'S NAME _____ **TODAY'S DATE** _____

LAST FIRST MIDDLE INITIAL

MEDICAL HISTORY – PLEASE CIRCLE THE APPROPRIATE ANSWER

1. Is your child in good health? ..... YES NO
2. Is your child under the care of a physician? ..... YES NO
   If yes, why? _____
3. Name of child's physician _____
   Physician phone number _____
4. Is your child taking any medications? ..... YES NO
   If yes, please list: _____
5. Has your child had any serious illness? ..... YES NO
   If yes, what and when? _____
6. Is your child allergic to penicillin, antibiotics or any other drugs? ..... YES NO
7. Is your child allergic or sensitive to any metals or latex? .....YES NO
8. Does your child have any other allergies? ..... YES NO
9. Does your child experience severe or prolonged bleeding? ..... YES NO
10. Is your child subject to nervous disorders, fainting, seizures, or dizziness? ..... YES NO
11. Has your child ever had surgery? ..... YES NO

Has your child had a history of, or conditions related to, any of the following:

☐ ADD/ADHD	☐ Developmental Delays	☐ Kidney Trouble
☐ AIDS/HIV+	☐ Diabetes	☐ Leukemia
☐ Anemia	☐ Earaches	☐ Liver Disease
☐ Artificial Heart Valve	☐ Emotional Problems	☐ Intellectual Disability
☐ Asthma	☐ Epilepsy (Seizures)	☐ Psychiatric Treatment
☐ Autism	☐ Headaches	☐ Respiratory Lung Disease
☐ Birth Defects	☐ Hearing/Sight Impaired	☐ Rheumatic Fever
☐ Blood Disorders/Bleeding Problems	☐ Heart Condition	☐ Scoliosis
☐ Brain Injury	☐ Heart Murmur	☐ Sickle Cell
☐ Cancer	☐ Hemophilia	☐ Speech Problems
☐ Cerebral Palsy	☐ Hepatitis	☐ Tonsillitis
☐ Cleft Lip/Palate	☐ Infections	☐ Tuberculosis

COMMENTS

DENTAL HISTORY – PLEASE CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? ..... YES NO
   If not, how long since the last visit to the dentist? _____
   Were any x-rays taken at your child's last visit? _____
2. Does your child eat between meals? ..... YES NO
3. Does your child eat sweets, such as candy, soda pop, chewing gum? ..... YES NO
4. How many times a day does your child brush? _____
5. When does your child brush his/her teeth?
   ☐ Upon arising ☐ After eating any food ☐ Right after meals ☐ Before going to bed
6. How does your child receive fluoride?
   ☐ Community water ☐ Well water ☐ Fluoride drops or tablets ☐ Fluoride rinse or gel
7. Have any cavities been noted in the past? ..... YES NO
8. Have any teeth (baby or permanent) been removed by extraction? ..... YES NO
9. Have there been any injuries to teeth, such as falls, blows, chips, etc.? ..... YES NO
10. Has your child had any problems with dental treatment in the past? ..... YES NO
11. Has anyone in the family, including parents, had orthodontics? ..... YES NO
12. Has your child ever received local anesthetics? ..... YES NO
13. Has your child ever had protective sealants placed? ..... YES NO
14. Does your child participate in active recreational activities? ..... YES NO

Does your child currently have any of the following habits:

☐ Breast Feeding ☐ Lip Sucking/Biting ☐ Nursing Bottle ☐ Tongue/Cheek Biting
☐ Chewing on Objects ☐ Mouth Breathing ☐ Pacifier
☐ Clenching Teeth ☐ Nail Biting ☐ Thumb/Finger Sucking

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. _____

PARENT/GUARDIAN SIGNATURE