



Welcome! We are pleased to welcome you and your child to our practice. Please help us get to know you better by taking a few minutes to fill out this form as completely as you can. Thank you!!

Patient Information

Today's Date: _____

Name: _____ Nickname: _____ DOB: _____ Age: _____

M _____ F _____ Address: _____ City _____ Zip: _____

Phone: _____ What school does your child attend? _____

Siblings (Name, age): _____ Are they patients here? _____

Whom may we thank for referring you to our office? _____

Hobbies, interests: _____

Is your child: Adopted Biological

Parent / Guardian Information

FATHER'S NAME: _____ DOB: _____ Marital status: (circle) S M D Sep W

Address (if diff): _____

Home Ph: _____ Cell ph: _____ Bus Ph: _____

SS#: _____ Driver's lic#: _____ Occupation: _____

Employer: _____ Employer address: _____

Email: _____ May we contact you via email? Y N

MOTHER'S NAME: _____ DOB: _____ Marital status: (circle) S M D Sep W

Address (if diff): _____

Home Ph: _____ Cell ph: _____ Bus Ph: _____

SS#: _____ Driver's lic#: _____ Occupation: _____

Employer: _____ Employer address: _____

Email: _____ May we contact you via email? Y N

Person financially responsible _____ Phone: _____

Legal guardian (if not parent): _____ Relationship to child _____

Financial Information

PRIMARY INSURANCE:

Name of insured: _____

Plan name: _____

Employer: _____

Group#: _____ Policy #: _____

SS#: _____ Ph #: _____

DOB: _____

SECONDARY INSURANCE:

Name of insured: _____

Plan name: _____

Employer: _____

Group#: _____ Policy #: _____

SS#: _____ Ph #: _____

DOB: _____

Dental History

Reason for today's visit: _____

Is your child in pain? _____

Is this your child's first dental visit? Y N If no, when was last exam? _____

Is your child taking any fluoride supplements or drinking fluoridated water? Y N

Has your child ever had an unfavorable experience at a dental office? Y N

Please explain: _____

How do you think your child will act toward the dentist? _____

Did your child use a bottle and for how long? _____

Any complications during pregnancy? _____

Has your child had history of:

Toothaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Trauma to tooth/ face/ chin	<input type="checkbox"/> Y <input type="checkbox"/> N	Lip/ cheek biting	<input type="checkbox"/> Y <input type="checkbox"/> N
Jaw pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Sensitivity to cold/hot	<input type="checkbox"/> Y <input type="checkbox"/> N	Pacifier	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding gums	<input type="checkbox"/> Y <input type="checkbox"/> N	Bad breath	<input type="checkbox"/> Y <input type="checkbox"/> N	Finger habit	<input type="checkbox"/> Y <input type="checkbox"/> N
Mouthbreathing	<input type="checkbox"/> Y <input type="checkbox"/> N	Clenching/ grinding	<input type="checkbox"/> Y <input type="checkbox"/> N	Tongue thrust	<input type="checkbox"/> Y <input type="checkbox"/> N

Medical History

Child's physician: _____ Date of last exam: _____

Address: _____ Ph #: _____

1. Is your child presently under the care of a physician for any medical problems? Y N

Please explain: _____

2. Is your child currently taking any medications? Y N

Please list: _____

3. Has your child ever been hospitalized or had surgery? Y N

Please explain: _____

4. Has your child ever had an unfavorable reaction to any of the following?

Antibiotics?	<input type="checkbox"/> Y <input type="checkbox"/> N	If "yes", for what and how?	_____
Local Anesthetic?	<input type="checkbox"/> Y <input type="checkbox"/> N	If "yes", for what and how?	_____
Latex ?	<input type="checkbox"/> Y <input type="checkbox"/> N	If "yes", how?	_____
Any metals?	<input type="checkbox"/> Y <input type="checkbox"/> N	If "yes", for what and how?	_____
Other food or medication allergy?	<input type="checkbox"/> Y <input type="checkbox"/> N	If "yes", for what and how?	_____

5. Has your child had history of any of the following:

Cardiac problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Learning disability	<input type="checkbox"/> Y <input type="checkbox"/> N	Immune System Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Sight/ Hearing Limitations	<input type="checkbox"/> Y <input type="checkbox"/> N
Rheumatic fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney/ Liver problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Neurological problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures/ Convulsions	<input type="checkbox"/> Y <input type="checkbox"/> N	Mental/ Emotional Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
ADD / ADHD	<input type="checkbox"/> Y <input type="checkbox"/> N	Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Asthma/ Breathing Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Brain injury	<input type="checkbox"/> Y <input type="checkbox"/> N	Down's Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N
Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Autism/ ASD	<input type="checkbox"/> Y <input type="checkbox"/> N	Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N

If "yes" to any question, **please explain:** _____

Is there anything else regarding your child's **physical, mental, or emotional health** that you feel we should know?

To optimally care for your child, may we send an introductory letter to your child's physician? No dental or medical information will be shared without further consent. Y N

I have reviewed the above to be correct to the best of my knowledge. _____

Signature

Date

Dr. Signature _____

Thank you for your time! Your answers will help us better provide for your child.
If you have any questions, please do not hesitate to ask.