



PATIENTS INFORMATION

Name _____ Nickname _____ Male Female SS# _____
 Pediatrician _____ Dr. Phone _____ Date of Birth _____ Age _____
 Name(s) and Age(s) of siblings in our practice _____
 Referred to us by _____

CONFIRMING INFORMATION

Which is the best contact number? home: _____ cell: _____
 Can we call you at work? yes no If yes, work number _____ Name _____
 E mail address to confirm appointment _____

PARENT OR LEGAL GUARDIAN INFORMATION

Do you have dental insurance? yes no

Person responsible for payment _____ Social Security # _____
 Father or legal guardian _____ Mother or legal guardian _____
 Address _____ Address _____
 City _____ City _____
 Zip _____ Phone _____ Zip _____ Phone _____
 Employed by _____ Employed by _____

Marital Status Married Widowed Separated Divorced Single

PATIENT MEDICAL HISTORY

Is your child adopted? Yes No Foster child? Yes No
 Is your child in poor health? Yes No If yes, explain _____
 Is your child under the care of a physician? Yes No If yes, explain _____
 Has your child ever had surgery Yes No If yes, explain _____
 Has your child ever had complications following dental treatment? Yes No If yes, explain _____
 Is surgery contemplated? Yes No If yes, explain _____
 Does your child have any health problems that need further clarification? Yes No If yes, explain _____
 List all medications your child is taking _____
 Last Dental Cleaning _____

Does you Child have/ever had any of the following? Please check those that apply

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Fainting | <input type="checkbox"/> Physically Impaired | <input type="checkbox"/> Food Allergy _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Growths | Due date: _____ | <input type="checkbox"/> Red Dye Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Tumors | <input type="checkbox"/> Depression | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other Drug Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | OTHER: _____ |
| <input type="checkbox"/> cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Acid Reflux | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Sickle Cell Trait | |
| <input type="checkbox"/> Autistic | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Sickle Cell Anemia | |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> VP Shunt | <input type="checkbox"/> Spina Bifida | |
| | <input type="checkbox"/> Nervous Disorders | | |

DENTAL HISTORY

Yes No

Is this the child's first visit to a dentist? _____
 Do you have fluoridated water at home? _____
 Have there been any injuries to teeth? _____
 If yes, please explain _____
 Has child had any unfavorable dental experience? _____
 Does child suck thumb or finger? _____
 Does child have any other habits? _____
 Does child still take bottle or breastfeed? _____
 Does parent help with oral hygiene? _____
 Does child have a TOOTHACHE? _____

Signature _____ Relationship _____ Date _____