Leo's Cub Club

Fallin Family Dentistry

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 _____

Address _____

City _____

Zip _____ Phone _____

Employed by _____

Mother or legal guardian _____

Address _____

City _____

Zip _____ Phone _____

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

❑ AIDS/HIV Positive
❑ Asthma
❑ ADHD/ADD
❑ Anemia
❑ Arthritis
❑ Artificial Joints
❑ Blood Transfusion
❑ Blood Disease
❑ cancer
❑ Diabetes
❑ Dizziness
❑ Epilepsy
❑ Excessive Bleeding
❑ Autistic
❑ Cerebral Palsy

❑ Fainting
❑ Glaucoma
❑ Growths
❑ Tumors
❑ Head Injuries
❑ Heart Disease
❑ Heart Murmur
❑ Hepatitis
❑ High Blood Pressure
❑ Jaundice
❑ Kidney Disease
❑ Liver Disease
❑ Mental Disorders
❑ Learning Disabilities
❑ VP Shunt
❑ Nervous Disorders

❑ Physically Impaired
❑ Pregnancy
Due date: _____
❑ Depression
❑ Respiratory Problems
❑ Rheumatic Fever
❑ Ulcers
❑ Sinus Problems
❑ Stomach Problems
❑ Stroke
❑ Tuberculosis
❑ Acid Reflux
❑ Sickle Cell Trait
❑ Sickle Cell Anemia
❑ Spina Bifida

❑ Food Allergy_____
❑ Seasonal Allergies
❑ Red Dye Allergy
❑ Latex Allergy
❑ Codeine Allergy
❑ Penicillin Allergy
❑ Other Drug Allergy
OTHER: _____
❑ _____
❑ _____

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 _____