

PATIENT INFORMATION & MEDICAL HISTORY

TELL US ABOUT YOUR CHILD

DATE _____

Child's Name _____ Nickname _____ Male Female

Child's Birthdate ___/___/___ Age _____ Height _____ Weight _____ Phone (____) _____

Address _____ City _____ State _____ Zip+4 _____

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

Previous/Present Dentist _____ Last Visit Date _____

Parent's Marital Status: Married Single Divorced Widowed

TELL US ABOUT YOUR CHILD'S HEALTH HISTORY

Why did you bring your child to the dentist today? _____

Has your child ever had a serious/difficult problem associated with previous dental work? Yes No

Is your child's water fluoridated? Yes No Is your child taking fluoride supplements? Yes No

Has your child ever had any pain/tenderness in his/her jaw or joint (TMJ/TMD) Yes No

Does your child brush his/her teeth daily? Yes No Floss daily? Yes No

Has your child ever had any of the following medical problems?

Y N Abnormal Bleeding	Y N Congenital Heart Defect	Y N Hemophilia
Y N Allergies to any drugs	Y N Convulsions/Epilepsy	Y N Hepatitis
Y N Any Operations	Y N Diabetes	Y N HIV/AIDS
Y N Asthma	Y N Handicaps/Disabilities	Y N Kidney/Liver Problems
Y N Cancer	Y N Hearing Impairment	Y N Rheumatic/Scarlet Fever
Y N Any Hospital Stays**	Y N Heart Murmur	Y N Tuberculosis (TB)

**Please explain reason(s) for hospital stay:

Does your child have any of the following habits?

Y N Lip Sucking/Biting	Y N Nail Biting
Y N Nursing Bottle Habits	Y N Thumb/Finger Sucking

Child's Physician _____

Has your child had any serious medical problems? _____

Please list all drugs that your child is currently taking: _____

Please list all drugs that your child is allergic to: _____

BILLING INFORMATION

Mother's Name _____ Step Mother Guardian Birthdate ____/____/____
Work Phone (____) _____ Ext. _____ Employer _____
Cell Phone (____) _____ SS# _____ DL# _____

Father's Name _____ Step Father Guardian Birthdate ____/____/____
Work Phone (____) _____ Ext. _____ Employer _____
Cell Phone (____) _____ SS# _____ DL# _____

Billing address if different from child's: _____

NEAREST RELATIVE NOT LIVING WITH YOU: Name _____ Phone (____) _____

Address _____ City _____ State _____ Zip+4 _____

INSURANCE INFORMATION

PRIMARY Dental Insurance

Insured's Name _____
Insurance Company _____
ID# _____
Group # _____
Insurance Address _____

Phone # _____

SECONDARY Dental Insurance

Insured's Name _____
Insurance Company _____
ID# _____
Group # _____
Insurance Address _____

Phone # _____

PLEASE NOTE: Your insurance is billed as a courtesy; you are responsible for your child's account.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian

Date