



PATIENT INFORMATION

Date: _____ Home Phone: _____ Cell Phone: _____

Name: _____
 Last Name _____ First Name _____ Middle Initial _____ Nickname: _____

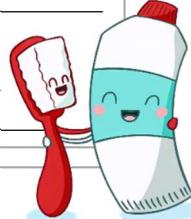
Sex: M F Current Age: _____ Birthdate: _____ SS/Patient ID: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Apt: _____

Patient's School: _____ Grade: _____

Whom may be thank for referring you? _____



PARENT/GUARDIAN INFORMATION – RESPONSIBLE PARTY

Name: _____
 Last Name _____ First Name _____ Middle Initial _____ Pref. Name: _____

Sex: M F Home Phone: _____ Cell Phone: _____

Birthdate: _____ Email: _____ Married Widowed Single

Address: _____ Separated Divorced Partnered for _____ years

City: _____ State: _____ Zip: _____ Apt: _____

Preferred Method of Communication: Text Call to the following phone number: _____
 Email to the following email address: _____

PARENT/GUARDIAN INFORMATION

Name: _____
 Last Name _____ First Name _____ Middle Initial _____ Pref. Name: _____

Sex: M F Home Phone: _____ Cell Phone: _____

Birthdate: _____ Email: _____ Married Widowed Single

Address: _____ Separated Divorced Partnered for _____ years

City: _____ State: _____ Zip: _____ Apt: _____

Preferred Method of Communication: Text Call to the following phone number: _____
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PRIMARY DENTAL INSURANCE

Subscriber's Name: _____
 Birthdate: _____ Relation to Child: _____
 Insurance Company: _____
 Subscriber ID: _____
 Home Address: _____
 City: _____ State: _____ Zip: _____
 Employer: _____

SECONDARY DENTAL INSURANCE

Subscriber's Name: _____
 Birthdate: _____ Relation to Child: _____
 Insurance Company: _____
 Subscriber ID: _____
 Home Address: _____
 City: _____ State: _____ Zip: _____
 Employer: _____

Please Complete Both Sides

DENTAL HISTORY

Reason for Today's Visit: _____

Former Dentist: _____ Address: _____

Date of Last Dental Care: _____ Date of Last Dental X-Rays: _____

Check (✓) if your child has had, or currently has, issues with any of the following:

- Bad breath
- Bleeding gums
- Clicking or popping jaw
- Food collection between teeth

- Grinding teeth
- Loose teeth or broken fillings
- Periodontal treatment
- Sensitivity to cold

- Sensitivity to hot
- Sensitivity to sweets
- Sensitivity when biting
- Sores or growths in the mouth

How often does your child floss? _____ How often does your child brush? _____



MEDICAL HISTORY

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

DOES YOUR CHILD:

- Suck Thumb/Finger..... Yes No
- Suck/Bite Lip..... Yes No
- Bite/Chew Nails..... Yes No
- Chew Hard Objects (pencils, etc.)..... Yes No
- Grind Teeth..... Yes No
- Clench Jaws..... Yes No
- Is your child's water fluoridated?..... Yes No
- Does your child take fluoride supplements?..... Yes No
- Has your child had difficulty with previous dental visits?..... Yes No

Child's Physician: _____

Address: _____

Phone #: _____

Pharmacy: _____

Address: _____

EMERGENCY CONTACT: _____

Phone Number: _____

Previous Hospitalizations/Surgeries/Illnesses Yes No

If yes, explain: _____

Has your child ever had any of the following?

- Acid Reflux..... Yes No
- Anemia..... Yes No
- Asthma..... Yes No
- Blood Transfusion..... Yes No
- Cancer..... Yes No
- Convulsions/Epilepsy..... Yes No
- Diabetes..... Yes No
- Food Allergies..... Yes No
- Handicaps/Disabilities..... Yes No
- Hearing Impairment..... Yes No
- Heart Problems..... Yes No

If yes, explain: _____

Is your child taking any medications? Yes No

If yes, please list: _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? Yes No

If yes, explain: _____

Does your child have a history of allergies to any other substances (environmental, latex, etc.)? Yes No

If yes, explain: _____

- Hemophilia/Abnormal Bleeding..... Yes No
- Hepatitis..... Yes No
- HIV/AIDS..... Yes No
- Persistent Cough..... Yes No
- Rheumatic Fever..... Yes No
- Stomach, Liver, or Kidney Problems..... Yes No
- Tuberculosis..... Yes No

Please list any other medical issues that your child has: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____