TRUE DENTAL

PATIENT INFORMATION

Date: _____ Home Phone: _____ Cell Phone: _____

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

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

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

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: _____

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

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: _____		
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

Child's Physician: _____

Address: _____

Phone #: _____

Pharmacy: _____

Address: _____

EMERGENCY CONTACT: _____

Phone Number: _____

Previous Hospitalizations/Surgeries/Illnesses ☐ 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: _____

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:** _____