

PATIENT INFORMATION

☐ Female

MI

ZIP

Cell Phone

Grade

Have we ever seen any of your children in our office?

Names of children:

Whom may we thank for referring you to our office?

Why did you bring your child to the dentist today?

FATHER			
LAST		FIRST	
STREET		CITY	STATE ZIP
HOME #		CELL #	
DATE OF BIRTH		SOCIAL SECURITY NUMBER	
EMPLOYER			
DENTAL INSURANCE CO		GROUP #	

NAME			
LAST		FIRST	
STREET		CITY	STATE ZIP
HOME #		CELL #	
DATE OF BIRTH		SOCIAL SECURITY NUMBER	
EMPLOYER			
DENTAL INSURANCE CO		GROUP #	

☐ Guardian

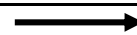
Address:

I hereby authorize payment directly to this dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers payers and/or other health professionals.

Date:

☐ Mother ☐ Father ☐ Guardian ☐ Other (relationship) _____

OVER



HEALTH HISTORY

Has your child ever been to the dentist?	Yes	No
Date of Last Visit? _____		
Has your child ever had a serious/difficult problem associated with previous dental work?	Yes	No
Is your water fluoridated?	Yes	No
Is your child taking a fluoride supplement?	Yes	No
Has your child ever had an injury to the face, mouth, or teeth?	Yes	No
Has your child ever had:		
Tooth Aches?	Yes	No
Bleeding Gums?	Yes	No
Missing Teeth?	Yes	No
Does your child brush his/her teeth daily?	Yes	No
Does your child floss daily?	Yes	No
Child's Pediatrician: _____		
Phone # _____ Date of Treatment: _____		
Is your child currently under the care of a physician?	Yes	No
Please describe your child's current physical health:		
<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		

Please list all drugs that the child is currently taking:	

Please list all drugs that your child is allergic to:	

Is your child allergic to latex gloves? _____	

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?			
Thumb/Finger Sucking	<input type="checkbox"/>	Grinding/Clenching	<input type="checkbox"/>
Lip Sucking/Biting	<input type="checkbox"/>	Mouth Breathing	<input type="checkbox"/>
Nail Biting	<input type="checkbox"/>	Tongue Thrust	<input type="checkbox"/>
Cheek Biting	<input type="checkbox"/>	Tongue Tied	<input type="checkbox"/>
Nursing Bottle Habit	<input type="checkbox"/>	Pacifier Habit	<input type="checkbox"/>
Doctor's Comments: _____			

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING PROBLEMS:			
Heart Problems	<input type="checkbox"/>	Fainting/Dizziness	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	Nervous Disorder	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Brain Injury	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>
AIDS/HIV+	<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	Bone Disorders	<input type="checkbox"/>
Hepatitis A or B	<input type="checkbox"/>	Sore Throats	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Ear Aches	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>
Liver Problems	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Eye Disorders	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Measles	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	Mumps	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Allergies	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>
Endocrine Problems	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>
Autism	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>
Downs Syndrome	<input type="checkbox"/>		
Please discuss any serious medical problems that your child has had: _____			

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA, including the heat autoclave sterilization of handpieces.

AUTHORIZATION

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

Signature: _____ Date: _____

OFFICE USE ONLY

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I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initial: _____ Date: _____