



PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your child's dental health.

Patient name _____ Preferred name _____

Birth date: ___/___/___ School _____ Grade _____

Reason for visit _____ Male/Female

Parent/ Guardian Information

Name _____ Birth date: ___/___/___

Home Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

E-Mail _____ Relationship to child _____

Employer _____ Occupation _____

Parent/ Guardian Information

Name _____ Birth date: ___/___/___

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

E-Mail _____ Relationship to child _____

Employer _____ Occupation _____

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

Internet/Website Flyer/ Mail Dentist Physician Other

Primary Carrier

Secondary Carrier

Insurance Co. _____ Insurance Co. _____

Ins. Phone#: _____ Ins. Phone#: _____

Policy holder: _____ Policy holder: _____

DOB: ___/___/___ DOB: ___/___/___

ID#/SSN: _____ ID#/SSN: _____

Group # _____ Group # _____

Patients Name _____

Date of Birth ___/___/___

Dental History

Is this your child's first dental visit? Yes No

How often does your child brush? _____

Previous dentist _____ City _____ State _____

Date of last visit _____

How do you think your child will react towards the dentist? _____

Has your child had any negative experiences at the dentist before? _____

Does your child do any of the following? (Please check any that apply)

- Brushes with fluoridated toothpaste
- Takes fluoride supplements
- Brushes with help from an adult
- Uses dental floss
- Eats or drinks after brushing at night
- Drinks only bottled water
- Drinks Juice
- Drinks sports drinks
- Child falls asleep with milk or juice
- Child uses a bottle with milk or juice
- Child uses a sippy cup
- Nursing during the day
- Nursing to sleep
- Chewing objects
- Nail biting
- Grinding
- Thumb sucking
- Lip sucking
- Finger sucking
- Pacifier
- Mouth breather
- Snores
- Injury to child's teeth (falls, chips)

Patient's Name _____

MEDICAL HEALTH HISTORY

Does your child have or has your child had any of the following?

(Please check any that apply)

- Cancer or tumor
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever
- Artificial joint or valve
- High or low blood pressure
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Blood transfusion; Date of last transfusion

- _____
- Diabetes
- Epilepsy, seizures, or fainting spells
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Fractured Jaw
- Anemia or blood disorders
- Hay Fever or sinus trouble
- Allergies or hives
- Asthma
- Autism
- ADHD/ADD
- Premature Birth
- Hearing Problems
- Intellectual Disability
- Congenital Birth Defects
- Speech Problems
- Behavioral Problems
- Pregnancy
- Radiation Treatment
- Autoimmune System Problems

Is your child allergic to, or has your child reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: _____

Name of child's physician _____ Phone Number _____

Is your child taking any medication? What? _____

Has your child ever been hospitalized or had surgery? For what? _____

Is your child allergic to any food or medicine? What? _____

Does your child have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about _____

Signature of Parent or Guardian _____ Date _____