Welcome! **We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.**

Patient Information

Date: _____

Child's Name _____ Male or Female

Age_____ Date of Birth_____ Preferred Name _____ School _____

Home Address _____ Phone _____
Street City State Zip

Whom may we thank for referring you? _____

Parent Information

Father's Name _____ Soc.Sec #_____ Date of Birth _____

Address _____ Phone _____
(if different from patient's) Street City State Zip (if different from patient's)

Father's Occupation _____ Employer _____

Work Phone _____ Cell Phone _____ Drivers License # _____

Mother's Name _____ Soc.Sec #_____ Date of Birth _____

Address _____ Phone _____
(if different from patient's) Street City State Zip (if different from patient's)

Mother's Occupation _____ Employer _____

Work Phone _____ Cell Phone _____ Drivers License # _____

Email Address: _____

How would you like us to confirm your appointment? Home Cell Text Email

Person responsible for Account _____

Is your child covered by your dental insurance plan? Yes No

Primary Dental Insurance

Insurance Co. Name _____ Insurance Co. Phone _____

Insurance Co. Address _____ Policy Holder _____

Member ID number _____

The medical and dental history questions provide us with important information to evaluate, diagnose and treat your child. Please answer all the questions. If there are any questions that you do not understand, please ask us for help. We will be happy to assist you. All information is held in the strictest confidence. Thank you for taking the time in this regard, it helps us to provide superior care.

Medical History

Child's Physician _____ Phone _____ Date of last exam _____

Is your child presently under medical care? Yes No If yes, explain _____

Is your child currently taking medications? Yes No Reason _____

Please list all medications _____

Does your child have allergies or reactions? Yes No Allergic to _____
(medications, drugs, foods, anything)

Has your child ever been hospitalized? Yes No Reason _____ Date _____

Has your child ever had surgery
under general anesthesia? Yes No Reason _____ Date _____

Has your child ever had a blood transfusion? Yes No Date _____

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

Yes	No	Heart Disease	Yes	No	Liver Problems	Yes	No	Cancer
Yes	No	Heart Murmur	Yes	No	Kidney Problems	Yes	No	Tuberculosis
Yes	No	Congenital Heart Defect	Yes	No	HIV+/AIDS	Yes	No	Bone Problems
Yes	No	Rheumatic Fever	Yes	No	Epilepsy	Yes	No	Asthma
Yes	No	Bleeding Disorder	Yes	No	Diabetes	Yes	No	Hearing Loss
Yes	No	Hemophilia	Yes	No	Hepatitis	Yes	No	Vision Loss

Other Medical Conditions _____

Characterize your child's mental development: Normal 1-2 years behind More than 2 years behind

Dental History

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

Has your child ever been to the dentist? Yes No Date of last dental visit _____

Characterize your child's past dental experiences: _____

Briefly describe your child's oral hygiene routine: _____

Does your child have a finger, thumb or pacifier habit? Yes No

Does your child's jaw make noise or is there pain associated with jaw movement? Yes No

Briefly describe any past dental trauma: _____ Date _____

Circle all water sources your child uses: Tap tap/filtered well bottled bottled with fluoride

Has your child ever taken fluoride supplements? Yes No

I understand the information given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical condition.

Signature of parent or guardian _____ Date _____