Demographic Information

Today's date: _____

Patient's full name: _____

Preferred name: _____Date of Birth: _____Age: _____Gender: M or F

Name of school or daycare: _____Grade: _____

Legal Guardian 1: _____ relation to patient: _____

Home address: _____Date of Birth: _____

Home phone#: _____Cell phone #: _____ Work #: _____

Employer: _____ SSN # *(for insurance purposes only)*: _____

Legal Guardian 2: _____ relation to patient: _____

Home address: _____Date of Birth: _____

Home phone#: _____Cell phone #: _____ Work #: _____

Employer: _____ SSN # *(for insurance purposes only)*: _____

Name of guardian accompanying patient today: _____

Can we confirm appointments via text? Yes or No If yes, phone #_____

Can we confirm appointments via email? Yes or No If yes, email:

_____

Names and ages of other children in family: _____

Whom may we thank for referring you to us? _____

What is the reason for your child's dental visit? _____

_____

Insurance Information

Does the patient have dental insurance? Yes or No

Insurance Company: _____Group#: _____ID#_____

Name of policy holder: _____DOB:_____SSN#_____

Medical History

Name of child's physician: _____Phone#_____

____Yes ____ No Is your child in good health? Date of last physical exam: _____

____Yes ____ No Has your child ever been hospitalized? If so, why? when? _____

____Yes ____ No Is your child allergic to anything? If yes, _____

____Yes ____ No Is your child currently taking and medications? If so, please list: _____

____Yes ____ No Were there any problems at birth? Was he/she born prematurely? If so please tell us about it: _____

____Yes ____ No Are your child's immunizations up to date?

Please mark if your child has been diagnosed with any of the following:

__AIDS/HIV	__Cancers/tumors	__Eye problems	__MRSA
__ADHD/ADD	__Cerebral palsy	__Frequent infections	__Physical delays
__Anemia	__Cleft lip/palate	__Heart problems	__Psychological dis.
__Asthma	__Congenital birth defects	__Hepatitis	__Reflux/GERD
__Autism Spectrum	__Diabetes	__Kidney disease	__Rheumatic fever
__Bleeding disorder	__Down Syndrome	__Liver/GI disease	__Seizures
__Vitamin B deficiency	__Endocrine disorder	__Mental delays	__Other problems

If other, please list_____
_____

DENTAL HISTORY

__Yes __No Has your child ever been to the dentist? If yes, where? _____
date of last visit_____ date of x-rays (if taken) _____

__Yes __No Has your child ever experienced any unfavorable reaction to dental treatment? If yes, _____

__Yes __No Are your child's teeth brushed 2 or more times a day?

__Yes __No Are your child's teeth flossed once a day?

__Yes __No Does your child use the following types of fluoride? (check below, if yes)
___ Drops/tabs? ___ Toothpaste? ___ Mouth rinse?

__Yes __No Does your child drink fluoridated water? ___I don't know

__Yes __No Has your child had any injuries to his/her teeth, jaw, face?

__Yes __No Does your child suck a finger, thumb, pacifier or tongue thrust? (circle one)

Please check if your child has had problems with any of the following:

_____ Cavities _____Teeth sensitive to hot/cold _____ Grinds teeth _____Toothaches

_____ Bleeding Gums _____Appearance of teeth _____Clicking or pain in jaw joints

_____Other dental problem (Please list_____)

To the best of my knowledge, the answers I have given are accurate. I understand it is important to report changes in my child's medical or dental status to the dentist, and I agree to do so. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment.

Signature: _____**Date:** _____