PATIENT INFORMATION

Patient Name:_____Date:_____
First MI Last

Preferred Name:_____Date of Birth_____M____F_____

Address:_____
Street City State Zip Code

Siblings names and ages:_____

Is child adopted? **Y** **N** If yes, does child know? **Y** **N**

Who is accompanying child at this visit?_____
Name Relationship

Parent one/Legal Guardian one

Name:_____DOB:_____/_____/_____
First MI Last

Relationship to child:_____ Do you have legal custody of child? **Y** **N**

SS#_____ Marital status: Married Single Separated Divorced Other

Address (if different from child's)_____

Home Phone_____Cell_____Work_____

Employer_____Occupation_____

Email_____

Parent two/Legal Guardian two

Name:_____ DOB:_____/_____/_____
First MI Last

Relationship to child:_____ Do you have legal custody of child? **Y** **N**

SS#_____ Marital status: Married Single Separated Divorced Other

Address (if different from child's)_____

Home Phone_____Cell_____Work_____

Employer_____Occupation_____

Email_____

Dental Insurance Information

Primary

Policy holders name_____ SS#_____
Policy holders DOB____/____/____ ID#_____ Group#_____
Name of Employer_____
Name of Insurance Co._____ Phone#_____
Insurance Co. Address_____

Secondary

Policy holders name_____SS#_____
Policy holders DOB____/____/____ ID#_____Group#_____
Name of Employer_____
Name of Insurance Co._____Phone#_____
Insurance Co. Address_____

Patient Health History

How often does your child brush?_____ Floss?_____
Is brushing/flossing supervised? **Y N** Does your child use a mouth rinse? **Y N**
Does your child use a fluoridated toothpaste? **Y N** Is your water fluoridated? **Y N**
Do you have any dental concerns or questions?_____
Do any of the following apply to your child:

Frequent snacking?	**Y N**	Breast-feeding?	**Y N**	Sleeping with a bottle?	**Y N**
Pacifier Use?	**Y N**	Tooth grinding?	**Y N**	Thumb sucking?	**Y N**
Sippy cup use?	**Y N**	Fingers in mouth?	**Y N**	Objects in mouth?	**Y N**

Previous Dentist_____ Date of last exam_____
Phone #_____
Child's Physician_____ Phone #_____
Does child need premedication prior to dental treatment **Y N** Why?_____
Is your **child allergic** to any medications or substances? **Y N**
List:_____
Is your child taking any medications (include dietary supplements, vitamins, or herbal medications)? **Y N**
Please give medication, dose and reason:

_____

Please indicate Yes or No if your child presently has or previously had any of the following:

Y N AIDS/HIV	Y N Down Syndrome	Y N Kidney/Liver disease	Y N Strep Throat
Y N Anemia	Y N Ear disorder/hearing loss	Y N Lung disease	Y N Stomach problem
Y N Asthma/Breathing problems	Y N Epilepsy/Seizures	Y N Measles/Mumps	Y N Tuberculosis
Y N Autism/ASD	Y N Eye disorder/blindness	Y N Muscle disorder	Y N Vision Problems
Y N Bleeding tendency	Y N Fainting/Dizziness/Headaches	Y N Nose/Throat disorder	Y N Other
Y N Blood disease/Transfusion	Y N Hayfever/Seasonal Allergies	Y N Nutritional disorder	
Y N Bone disorder	Y N Heart Condition/Murmur	Y N Prolonged illness	
Y N Cancer/Tumors	Y N Hepatitis	Y N Rheumatic fever	
Y N Cerebral Palsy	Y N Hormone Disorder	Y N Sickle Cell Anemia/Trait	
Y N Chicken Pox	Y N Hyperactive/ADD/ADHD	Y N Skin disease	
Y N Diabetes/Endocrine problems	Y N Jaundice	Y N Speech problem	

Dentist Review, Health Updates:

Review, Initial, Date	List Medications