PATIENT CHILD INFORMATION

Patient's Name _____ Today's Date _____
Home Address _____
City_____ Zip_____ Res. Tel.#_____
Social Security # _____-____-_____ Date of Birth ____/____/____ Age_____ Marital Status S/M/D/W
Father's Name_____ Social Security # _____-_____-_____
Email: _____ Employer_____
Mother's Name_____ Social Security # _____-_____-_____
Email: _____ Employer_____

PERSON TO CONTACT IN AN EMERGENCY_____ Relation_____
Cell Tel. #_____ Email: _____
RESPONSIBLE PARTY FOR ACCOUNT_____
Cell Tel. # _____ Email: _____
Mother Drivers License: _____ Fathers Drivers License: _____
Whom may we thank for referring you?_____ **Google:** _____

INSURANCE INFORMATION

Insured_____ Insured's SS #_____-_____-_____ Insured's DOB ____-____-_____
Insurance Co._____ Insurance Co. Tel_____ Group #_____

SECONDARY INSURANCE INFORMATION

Insured_____ Insured's SS #_____-_____-____ Insured's DOB _____-____-____
Insurance Co._____ Insurance Co. Tel_____ Group #_____

DENTAL HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating your child, please carefully review this form completely and fill out all areas which pertain to your child.
ALL THIS INFORMATION IS CONFIDENTIAL

Dental History:

Previous Dentist_____ City_____ How long_____
Date of last visit_____ Date of last dental cleaning_____ Date of last full mouth x-ray_____
1.) Why did your child leave their last dentist?_____
2.) What did your child like most about any dentist, or a dental office they have been to?_____
3.) What did your child like least about any dentist, or dental office that they have been to?_____

Check any of the following your child has had or currently has:

____Mouth discomfort
____Periodontal Treatment
____Trenchmouth or Pyorrhea
____Gum Abscesses
____Gums Bleed when Brushing
____Loose or Shifting Teeth
____Trouble Chewing/Speaking
____Bruise Easily
____Grind or Clench your teeth
____Pain, Clicking, Popping in Jaw Joints
____Orthodontic Treatment
____Awake with Sore Jaws
____ Sealents
____Mouth Odor or Bad Taste
____Cold Sores or Fever Blisters
____Other Oral Lesions
____Immediate Relatives that have lost all of their Natural Teeth
____Bad Dental Experience
____Complications With or Following previous Dental or Oral Surgical treatment
____Sensitive Teeth (Hot, Cold, Sweets)
____Fear of Dental Treatment
____Sucks Thumb
____ Injuries to teeth by trauma

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If your child could change one thing about your child's smile, what would that be?_____
_____
If there was a simple, inexpensive way to whiten your child's teeth, would you be interested? Y N
Do you want to keep your child's teeth?
____ Yes. No matter how much trouble ____ I don't know
____ Yes. If it's not too much trouble ____ I don't care

Medical Health History:

1.0 Describe your child's present health Excellent Good Fair Poor

2.0 List your child's current Physician(s): a._____ Type_____

b._____ Type_____

3.0 Date of your child's last physical exam _____/_____/_____ Purpose_____

4.0 Are you aware of any changes in your child's general health in the last year? No Yes_____

5.0 Has your child been hospitalized for illness or surgery in the past two years? No Yes_____

6.0 Has your child been under a medical doctor's care during the past two years? No Yes_____

7.0 Has your child ever had excessive bleeding that required special treatment? No Yes_____

8.0 Is there any history of diabetes in your family? No Yes_____

9.0 Is your child on a special or restricted diet of any kind? No Yes_____

10.0 Do you or your child smoke? No Yes How much?_____ How long?_____

11.0 List all medications your child is now taking (include over the counter)_____

_____

List all medications your child is allergic to:_____

_____

Is your child sensitive to metal or latex gloves**?** _____

Indicate which of the following your child has had or presently has:

Heart Trouble	No/Yes	Shortness of Breath	No/Yes	Contact Lenses	No/Yes
Kidney or Bladder Trouble	No/Yes	Cancers or Tumors	No/Yes	Radiation Treatment	No/Yes
High Blood Pressure	No/Yes	Chemotherapy	No/Yes	Weight Loss/Gain	No/Yes
Low Blood Pressure	No/Yes	Radiation Treatment	No/Yes	Psychiatric Care	No/Yes
Heart Murmur	No/Yes	Persistent Cough	No/Yes	Ulcers	No/Yes
Rheumatic Fever	No/Yes	Tuberculosis	No/Yes	Contact Lenses	No/Yes
Congenital Heart Lesions	No/Yes	Asthma	No/Yes	Hepatitis	No/Yes
Artificial Heart Valve	No/Yes	Hay Fever	No/Yes	Liver Disease	No/Yes
Scarlet Fever	No/Yes	Sinus Trouble	No/Yes	Jaundice	No/Yes
Blood Transfusions	No/Yes	Allergies or Hives	No/Yes	Drug/Alcohol Addict.	No/Yes
Anemia	No/Yes	Frequent Thirst/Urination	No/Yes	AIDS	No/Yes
Sickle Cell Disease	No/Yes	Diabetes	No/Yes	HIV+	No/Yes
Frequent Headaches	No/Yes	A Nervous Person	No/Yes	Thyroid Disease	No/Yes
Ankles Swell	No/Yes	Epilepsy or Seizures	No/Yes		
		Fainting or Dizzy Spells	No/Yes		

If Female, is your child Pregnant? No/Yes Birth Control Pills No/Yes

Does your child have any medical conditions or diseases we should know about? No/Yes

Explain:_____

_____

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To the best of my knowledge, all the preceding answers are true and correct. If my child has any changes in his/her health or medicines, I will inform the Doctor on or before their next appointment, without fail.

Parent's Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____