

PATIENT CHILD INFORMATION

Patient's Name _____ Today's Date _____
 Home Address _____
 City _____ Zip _____ Res. Tel.# _____
 Social Security # _____ - _____ - _____ Date of Birth ____/____/____ Age _____
 Name of School _____ Teacher _____ Marital Status S/M/D/W _____
 Father's Name _____ Social Security # _____ - _____ - _____
 Father's Occupation _____ Employer _____ Bus.Tel# _____
 Mother's Name _____ Social Security # _____ - _____ - _____
 Mother's Occupation _____ Employer _____ Bus.Tel# _____

PERSON TO CONTACT IN AN EMERGENCY _____ Relation _____
 Res. Tel. # _____ Bus. Tel. # _____ Address _____
 RESPONSIBLE PARTY FOR ACCOUNT _____ Bus Tel. # _____ Res. Tel.# _____
 Reason for this visit _____
 Whom may we thank for referring you? _____

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:

- | | |
|--|---|
| <input type="checkbox"/> Mouth discomfort | <input type="checkbox"/> Sealants |
| <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Mouth Odor or Bad Taste |
| <input type="checkbox"/> Trenchmouth or Pyorrhea | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Gum Abscesses | <input type="checkbox"/> Other Oral Lesions |
| <input type="checkbox"/> Gums Bleed when Brushing | <input type="checkbox"/> Immediate Relatives that have lost all of their Natural Teeth |
| <input type="checkbox"/> Loose or Shifting Teeth | <input type="checkbox"/> Bad Dental Experience |
| <input type="checkbox"/> Trouble Chewing/Speaking | <input type="checkbox"/> Complications With or Following previous Dental or Oral Surgical treatment |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Sensitive Teeth (Hot, Cold, Sweets) |
| <input type="checkbox"/> Grind or Clench your teeth | <input type="checkbox"/> Fear of Dental Treatment |
| <input type="checkbox"/> Pain, Clicking, Popping in Jaw Joints | <input type="checkbox"/> Sucks Thumb |
| <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Injuries to teeth by trauma |
| <input type="checkbox"/> Awake with Sore Jaws | |

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?

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Yes. No matter how much trouble | <input type="checkbox"/> I don't know |
| <input type="checkbox"/> Yes. If it's not too much trouble | <input type="checkbox"/> I don't care |

