PATIENT INFORMATION

Date : _____
Patient Name : _____ Sex : M_____F_____
Social Security # _____ Birth Date : _____
Best Contact # _____(home work cell) Other #_____
Address : _____
City / Zip code : _____
Parent / Guardian : _____
E=Mail : _____
Pharmacy name & number : _____

Parent/Guardian Occupation _____ Work Phone_____
Employer Name and Address _____
_____

Other Family Members: _____
HOW DID YOU HEAR ABOUT OUR OFFICE?
_____

INSURANCE INFORMATION

Primary
Name of Insured _____Relation to Patient: Self/Child
Insured's Birthday_____ Soc. Security # _____
Address _____
Insured's Employer Name & Address _____
_____
Insurance Plan Name_____ Client#/ ID#_____
Secondary Insurance _____
_____

Signature_____

Child's Name_____ Date_____

Dental Health History

1. Parent's Dentist_____

2. Please check reason(s) for today's visit:

_____First Visit	_____Accident
_____Routine check-up	_____Crooked teeth
_____Toothache or swelling	_____Other_____

3. Has the child been to a dentist before today?__yes__no
   If yes, when was last visit?_____
   & what was done?_____

4. How do you think your child will do today?
   _____

5. Does your child brush on his/her teeth by themselves, without any help? _____Y ____N

6. Does he/she use dental floss? ____Y ___N

7. Do you help?__Y__N When & how often?_____

8. Does your child take fluoride? ____Y ___N

9. Have your child's teeth ever been injured? __Y__N

   Please describe (when,how,which teeth)
   _____
   _____

10. List the typical snacks that your child eats.
    _____

11. Check any that apply:

_____thumb or finger sucking	____pacifier
_____ uses baby bottle	____snoring
_____picky eater	

_____
Caregiver's signature

Medical History

Child's Name: _____ Date:_____

Child's Physician: _____

Any problems with pregnancy? _____

Any problems with child birth? _____

Any problems in the first year of life? _____

Is child being treated for any specific illness right now? _____

Is child taking any medications presently? Please list: _____

Has your child shown any allergies or unusual reactions to;

A. Medications or prescriptions _____
B. Foods _____
C. Other _____

Has your child ever been hospitalized? Date: _____

Reason:_____

Has your child ever had an operation? Date: _____

Reason:_____

Has your child ever had any of the following? Please circle yes or no.

Rheumatic Fever :	Y N	Heart Murmur:	Y N	Lyme Disease:	Y N	Asthma:	Y N
Bleeding Problems:	Y N	Diabetes:	Y N	Seizures:	Y N	HIV/Aids:	Y N
Liver Disease:	Y N	Cancer:	Y N	Kidney Disease:	Y N	Anemia:	Y N
Joint Replacement:	Y N	Dizziness/Fainting:	Y N	Hearing Disability:	Y N		
Mental Disorders:	Y N	Emotional Disorders:	Y N	Learning Disorders:	Y N		

Other: _____

Any additional information (medical, family, social or otherwise) that we should know in order to best treat your child? _____

Parent/Guardian Signature:_____ _____ Date: _____

Dental Provider Signature: _____ Date: _____