



## Tell Us About Your Child

Today's Date: \_\_\_/\_\_\_/\_\_\_ Preferred Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
LAST FIRST MI

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## General Information

Who is accompanying child today?  
\_\_\_\_\_

Do you have legal custody of this child? Y / N

Whom may we thank for referring you?  
\_\_\_\_\_

Other siblings/ages: \_\_\_\_\_

Hobbies: \_\_\_\_\_

## Parents' Information

**Father**  **Stepfather**  **Guardian**

**Mother**  **Stepmother**  **Guardian**

Marital Status: S M D W Birthdate: \_\_\_/\_\_\_/\_\_\_

Marital Status: S M D W Birthdate: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: (If different than child's)  
\_\_\_\_\_  
\_\_\_\_\_

Address: (If different than child's)  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

Work Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

### PRIMARY DENTAL INSURANCE

### SECONDARY DENTAL INSURANCE

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Insured's ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Phone: \_\_\_\_\_

Ins. Phone: \_\_\_\_\_

Driver's License: \_\_\_\_\_ SS#: \_\_\_\_\_

Driver's License: \_\_\_\_\_ SS#: \_\_\_\_\_

# Dental and Medical History

Has your child been to a dentist before? Y / N Previous General Dentist: \_\_\_\_\_

Last Dental Visit: \_\_\_\_\_ What are the main concerns?: \_\_\_\_\_

Is your child currently in pain? Y / N Please specify: \_\_\_\_\_ Any pain in the jaw joint? Y / N

Has your child experienced any unfavorable reaction from any previous dental care? Y / N Please specify: \_\_\_\_\_

Please rate your child's oral health: Good / Fair / Poor Does your child brush his/her teeth daily? Y / N

Does your child require antibiotics before dental procedures? Y / N If yes, please specify reason: \_\_\_\_\_

Are you currently under a physician's care? Y / N If yes, explain: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Date of last visit to physician: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Please rate your child's mental health: Good Fair Poor

Are you taking any medicine at this time? Y / N Please specify: \_\_\_\_\_

Are you allergic to any medications? Y / N Please specify: \_\_\_\_\_

Are you allergic to the following medications?

Yes / No Penicillin Yes / No Tetracycline Yes / No Erythromycin Yes / No Aspirin Yes / No Dental Anesthetics Yes / No Codeine Yes / No Sulfa

Do you have any known allergies (latex, nickel, nuts, etc.)? Y / N Please specify: \_\_\_\_\_

Have you been hospitalized or had any surgeries? Y / N Please specify: \_\_\_\_\_

Do you have any history of these?:

Yes / No Heart attack / Stroke	Yes / No Sinus Problems	Yes / No Heart Disorder/Murmur/Defects	Yes / No Hepatitis or Liver Disorder
Yes / No Anemia / Bleeding Disorders	Yes / No Difficulty Breathing	Yes / No Artificial valves	Yes / No Kidney or Bladder Disorder
Yes / No Prolonged Bleeding/Clotting Disorder	Yes / No Asthma	Yes / No Hypertension	Yes / No Ulcers / Colitis
Yes / No Bone Problem or Disorder	Yes / No Bronchitis	Yes / No Congenital Heart Disease	Yes / No Pacemaker
Yes / No Arthritis/Joint Swelling	Yes / No Tuberculosis	Yes / No Heart Surgery	Yes / No Emotional Disorders
Yes / No Artificial Joints	Yes / No Neurologic Disorder	Yes / No Rheumatic Fever	Yes / No Hearing difficulties
Yes / No AIDS or HIV	Yes / No Cerebral Palsy	Yes / No Mitral Valve Prolapse	Yes / No Daily Aspirin/Blood Thinner
Yes / No Cancer / Chemotherapy / Radiation	Yes / No Convulsions/Seizures	Yes / No Endocrine/Hormone Disorders	Yes / No Pregnant (For women)
Yes / No Hearing Impairment	Yes / No Headaches	Yes / No Diabetes	_____ <b>Doctor's Initials</b>

If you are experiencing or have a history of any disease, condition, or problem not addressed, please explain:

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services that my child may need.

The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Signature of parent or guardian : \_\_\_\_\_ Date: \_\_\_\_\_