We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form, so we can best assess your child's dental care needs. The information provided is strictly confidential.

Today's Date: _________________

PATIENT INFORMATION

Child's Name:____ Nickname:___________
Last Name First Name Initial
Date of Birth: ____/____/____ Age:_______ Grade: _____________
Sex: □ Male □ Female Social Security #: _______________________
Address: ____
City:____ State: ______________ Zip:__________________
Primary Phone #: _________________________ Additional Phone #: ____________________________
Who may we thank for referring you?____

PRIMARY INSURANCE

Person Responsible for Account: ____
Name First Name Initial
Relation to Child: ________________________Date of Birth: ____/____/____ Soc. Sec#:____________
Address (if different to child):____
City: _____________________________________ State: _____________ Zip:______________
Primary Phone #: ___________________________ Additional Phone #: _______________________
Email: ____
Employer:_________________________________ Occupation:___________________________
Insurance Company:_________________________ Policy #:______________________________

EMERGENCY CONTACT

Name:____________________________________ Relationship:________________________________
Phone #:__________________________________ Additional #:_________________________________

DENTAL HISTORY

Reason for your child's visit today □ Cleaning □ Consultation □ Emergency □ Other
Is this your child's first dental visit? □ Yes □ No
Name of Former Dentist: _________________________ Date of last dental care: ___________________
How often does your child brush? __________________ Floss? _________________________________
Does your child experience pain or discomfort? □ Yes □ No
Has your child ever experience a mouth or chin injury? □ Yes □ No
Does your child have speech problems? □ Yes □ No
Has your child ever experienced an adverse reaction during any medical or dental procedure? □ Yes □ No

Does your child have any dental habits? □ Thumb sucking □ Nail Biting □ Grinding
□ Other: ____

Please share any concerns about your child's dental health or previous dental treatment: ____________
____

MEDICAL HISTORY

Child's Pediatrician/Physician Name: ___________________________ Phone: ______________________

Date of last visit and reason: ____

Is your child currently under physician care? □ Yes □ No If Yes: ____________________________
____

Has your child ever had any surgeries? □ Yes □ No If Yes: ____________________________
____

Has your child ever had any of the following? Please mark all that apply □ **NONE OF THE BELOW APPLY**

- □ AIDS/ HIV+
- □ Anemia / Leukemia
- □ Allergy- Seasonal
- □ Arthritis- Rheumatism
- □ Artificial Joint / Limb
- □ Asthma- Respiratory Problems
- □ ADD/ADHD
- □ Autism
- □ Behavioral / Learning / Emotional Disabilities
- □Birth Defects
  - □Developmentally Delayed
  - □Hydrocephalus
- □ Bleeding disorders: Sickel Cell/ Hemophilia
- □ Cancer/Tumors: ________________________
- □ Chemotherapy/ Radiation Treatment
- □ Cerebral Palsy
- □ Childhood Diseases: Measles/Mumps/Chicken Pox
- □ Cleft Lip Palate
- □ Convulsions: Seizures/Epilepsy
- □ Diabetes
- □ Digestive: Nutritional Disturbances
- □ Ear: Aches/ Hearing Loss/ Aids/Implants/Infections
- □ Eating Disorders: Anorexia/Bulimia
- □ Eyesight Problems: Glasses
- □ Fainting /Panic Attacks
- □ Endocrine/Glandular Disorder
- □ Heart Condition, Problem or Disease:
  - □ Heart Murmur
  - □ Heart Surgery
  - □ Heart Valve / Mitral Valve Prolapse
  - □ Rheumatic Fever
- □ High or Low Blood Pressure
- □ Hormonal Disorders
- □ Liver Disease: Hepatitis A, B or C
- □ Malignant Hyperthermia
- □ Muscular Disorders
- □ Organ Transplant
- □ Pregnancy
- □ Speech or swallowing problems
- □ Material Allergy: (Latex, wool, Chemicals, metal)
- □ Other: If yes Please explain: ________________________________
  ____

List of medications patient is taking: _________________
____
____

List Drug Allergies, if any:________________
____
____

AUTHORIZATION

-I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist.

-I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

-I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Parent/ Legal Guardian Signature: ____ Date: ______________

Relationship to Patient: ____