

**Patient Information**

Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender \_\_\_ M \_\_\_ F

Nickname \_\_\_\_\_ SS# \_\_\_\_\_

Responsibly Party Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Email address \_\_\_\_\_

\_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of School \_\_\_\_\_

Hobbies \_\_\_\_\_

Whom may we thank for referring you to our Dental Practice? \_\_\_\_\_

**Medical History**

Physicians Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Has your child been hospitalized or had a major operation? \_\_\_ Yes \_\_\_ No If Yes: \_\_\_\_\_

Has your child ever had a serious head or neck injury? \_\_\_ Yes \_\_\_ No If Yes: \_\_\_\_\_

Is your child taking any medications, pills or drugs \_\_\_ Yes \_\_\_ No If Yes: \_\_\_\_\_

Does your child take, or have taken Phen-Fen or Redux? \_\_\_ Yes \_\_\_ No

Was your child born prematurely/experienced complications at birth? \_\_\_ Yes \_\_\_ No

Is your child **allergic** to any medications? \_\_\_ Yes \_\_\_ No If yes, explain \_\_\_\_\_

Does your child have any other allergies? \_\_\_ Yes \_\_\_ No If yes, explain \_\_\_\_\_

Does your child require antibiotics before dental treatment? \_\_\_ Yes \_\_\_ No

Other \_\_\_\_\_

Does your child have or has had any of the following?

- |                           |                |                              |                |
|---------------------------|----------------|------------------------------|----------------|
| AIDS/HIV Positive         | ___ Yes ___ No | Hemophilia                   | ___ Yes ___ No |
| Anaphylaxis               | ___ Yes ___ No | High Blood Pressure          | ___ Yes ___ No |
| Anemia                    | ___ Yes ___ No | Hives or rash                | ___ Yes ___ No |
| Angina                    | ___ Yes ___ No | Hypoglycemia                 | ___ Yes ___ No |
| Artificial Joint          | ___ Yes ___ No | Kidney Problems              | ___ Yes ___ No |
| Asthma                    | ___ Yes ___ No | Leukemia                     | ___ Yes ___ No |
| Blood Transfusion         | ___ Yes ___ No | Liver Disease                | ___ Yes ___ No |
| Blood Disease             | ___ Yes ___ No | Lung Disease                 | ___ Yes ___ No |
| Breathing Problem         | ___ Yes ___ No | Rheumatic Fever              | ___ Yes ___ No |
| Cancer                    | ___ Yes ___ No | Sexually Transmitted Disease | ___ Yes ___ No |
| Cold Sores/Fever Blisters | ___ Yes ___ No | Sickle Cell Disease          | ___ Yes ___ No |
| Congenital Heart Disorder | ___ Yes ___ No | Sickle Cell Trait            | ___ Yes ___ No |
| Diabetes                  | ___ Yes ___ No | Sleep Apnea                  | ___ Yes ___ No |
| Drug Addiction            | ___ Yes ___ No | Strep Throat                 | ___ Yes ___ No |
| Epilepsy or Seizures      | ___ Yes ___ No | Tonsillitis                  | ___ Yes ___ No |
| Excessive Bleeding        | ___ Yes ___ No |                              |                |
| Fainting/Dizziness        | ___ Yes ___ No |                              |                |
| Glaucoma                  | ___ Yes ___ No |                              |                |
| Heart Murmur              | ___ Yes ___ No |                              |                |

Are there any other disabilities, handicaps or any medical problems that we need to be aware of?

\_\_\_\_\_

**Dental History**

Previous Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of last dental visit? \_\_\_\_\_

Has your child had difficulty with previous dental visits? If yes, Please explain  
\_\_\_\_\_

How often does your child brush? \_\_\_\_\_

How often does your child floss? \_\_\_\_\_

Is your child's water fluoridated? \_\_\_ Yes \_\_\_ No

Does your child suck thumb/finger \_\_\_ Yes \_\_\_ No

Does your child Bite/Chew nails? \_\_\_ Yes \_\_\_ No

Does your child grind teeth? \_\_\_ Yes \_\_\_ No

Does your child clench jaws? \_\_\_ Yes \_\_\_ No

Are you interested in braces? \_\_\_ Yes \_\_\_ No

**Primary Insurance**

Insured's Name \_\_\_\_\_

Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_

Member ID # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insurance Company Phone # \_\_\_\_\_

**Secondary Insurance**

Insured's Name \_\_\_\_\_

Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_

Member ID # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insurance Company Phone # \_\_\_\_\_

**Emergency Contact** In the event of an emergency, whom should we contact? \_\_\_\_\_

Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**Authorization & Release**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance carrier to pay directly to the Dentist or Dentist group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

\_\_\_\_\_  
Signature of patient (or parent/guardian if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Dentist

\_\_\_\_\_  
Date