PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ PREFERED NAME: _____

BIRTH DATE: _____/_____/_____ AGE: _____ WEIGHT: _____ SCHOOL: _____ GRADE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ CELL #: _____ EMAIL: _____

PATIENT LIVES WITH : MOTHER ( ) FATHER ( ) OTHER ( ) RELATIONSHIP TO CHILD: _____

PERSON RESPONSIBLE FOR ACCOUNT: _____ MOTHER ( ) FATHER ( ) OTHER ( ) RELATIONSHIP TO CHILD _____

RESPONSIBLE PARTY ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WHO CAN WE THANK FOR REFERRING YOU TO UR OFFICE? _____

PARENT/ GUARDIAN 1

NAME: _____

ADDRESS SAME AS PATIENT? ☐YES ☐ NO EMAIL: _____

PHONE # 1: _____ PHONE #2: _____

BIRTH DATE : _____ SOC. SEC.: _____

PARENT/ GUARDIAN 2

NAME: _____

ADDRESS SAME AS PATIENT? ☐YES ☐ NO EMAIL: _____

PHONE # 1: _____ PHONE #2: _____

BIRTH DATE : _____ SOC. SEC.: _____

DENTAL INSURANCE

NAME OF INSURED: _____ INSURED BIRTH DATE: _____ RELATIONSHIP TO INSURED: _____

INSURED SOC. SEC: _____ SUBSCRIBER ID: _____ GROUP#: _____

INSURED EMPLOYER: _____ INSURANCE COMPANY: _____ INSURANCE PHONE: _____

IF INSURED IS NOT REPOSNISBLE PARTY PLEASE PUT INSURED ADDRESS HERE: _____

IF THERE IS SECONDARY INSURANCE, PLEASE PUT INFORMATION HERE: _____

MEDICAL HISTORY

CHILD'S PEDIATRICIAN OR PRIMARY CARE PHYSICIAN'S NAME, ADDRESS, AND PHONE NUMBER (IF AVAILABLE):

_____

PLEASE INDICATE YES OR NO IN RESPONSE TO THE FOLLOWING QUESTIONS:

☐ YES ☐ NO DOES YOUR CHILD REQUIRE ANTIBIOTIC PREMEDICATION BEFORE DENTAL TREATMENTS (SBE PROPHYLAXIS)?

☐ YES ☐ NO HAS YOUR CHILD OR FAMILY MEMBERS EVER HAD COMPLICATIONS FOLLOWING A DENTAL TREATMENT, SEDATION, OR GENERAL ANESTHESIA?

☐ YES ☐ NO IS YOUR CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN DUE TO A SPECIFIC CONDITION?

☐ YES ☐ NO HAS YOUR CHILD EVER BEEN HOSPITALIZED DUE TO A SURGERY OR ILLNESS?

☐ YES ☐ NO DOES YOUR CHILD HAVE SNORING, OBSTRUCTIVE SLEEP APNEA, OR MOUTH BREATHING?

IF ANY OF THE PREVIOUS QUESTIONS ARE MARKED YES, PLEASE EXPLAIN: _____

_____

IS YOUR CHILD TAKING ANY PRESCRIPTION OR NON- PRESCRIPTION MEDICATIONS? ☐ YES ☐ NO

IF YES, PLEASE LIST BELOW, MEDICATION NAMES, DOSAGE, FREQUENCY TAKEN, AND WHAT CONDITIONS THEY ARE TAKEN FOR:

_____

_____

IS YOUR CHILD ALLERGIC TO: ☐ ASPIRIN ☐ CODEINE ☐ ERYTHROMYCIN ☐ LATEX (RUBBER) ☐ PENICILLIN ☐ SULFA ☐ OTHER _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

☐ADHD/ADD	☐CANER	☐EXCESSIVE BLEEDING	☐HEPATITIS	☐MENTAL DISORDER	☐SINUS PROBLEMS
☐ANEMIA	☐CEREBRAL PALSY	☐FAINTING	☐HEARING PROBLEMS	☐NERVOUS DISORDER	☐STOMACH PROBLEMS
☐ARTIFICIAL JOINTS	☐CLEFT LIP/ PALATE	☐GLAUCOMA	☐HIGH BLOOD PRESSURE	☐RADIATION TREATMENT	☐STROKE
☐ASTHMA	☐DIABETES	☐HEAD INJURY	☐HIV/ AIDS	☐RESPIRATORY PROBLEMS	☐SIGHT PROBLEMS
☐AUTISM	☐DEVELOPMENT DIS.	☐HEART DISEASE	☐JAUNDICE	☐RHEUMATIC FEVER	☐SPEECH PROBLEMS
☐BLOOD DISEASE	☐EPILEPSY/ SEIZURE	☐HEART MURMUR	☐KIDNEY /LIVER DISEASE	☐RHEUMATISM	☐TUBERCULOSIS

PLEASE EXPLAIN ANY MARKED ANSWERS: _____

DOES YOUR CHILD HAVE ANY OTHER CONDITIONS, DISEASES, OR ALLERGIES, ETC? _____

TEENAGE FEMALE PATIENT ONLY: IS YOUR TEEN PREGNANT? IF YES, WHEN IS THE DUE DATE? _____

DENTAL HISTORY

HOW FREQUENTLY DO ☐YOU ☐ YOUR CHILD BRUSH HIS/ HER TEETH? ☐3(+) A DAY ☐TWICE A DAY ☐ONCE A DAY ☐SELDOM

HOW FREQUENTLY DO ☐YOU ☐ YOUR CHILD FLOSS HIS/ HER TEETH? ☐1(+) A DAY ☐FEW TIMES A WEEK ☐SELDOM

PLEASE INDICATE YES OR NO TO THE FOLLOWING QUESTIONS (IF YES IS INDICATED, PLEASE ELABORATE):

☐YES ☐NO HAS YOUR CHILD PREVIOUSLY BEEN TO THE DENTIST? IF YES, WERE X-RAYS TAKEN ☐YES ☐NO DENTIST NAME: _____

☐YES ☐NO DOES YOUR CHILD'S GUMS BLEED DURING BRUSHING OR FLOSSING? _____

☐YES ☐NO DOES YOUR CHILD EXPERIENCE TOOTH SENSITIVITY TO COLD OR HOT TEMPERATURES? _____

☐YES ☐NO IS YOUR CHILD EXPERIENCING ANY TOOTH OR JAW PAIN /TENDERNESS? _____

☐YES ☐NO DOES YOUR CHILD GRIND HIS/HER TEETH? _____

☐YES ☐NO HAS YOUR CHILD HAD ANY INJURIES TO HIS/HER TEETH? _____

☐YES ☐NO HAS YOUR CHILD EVER HAD A TOOTH EXTRACTED? IF YES, WERE THERE ANY PROBLEMS? ☐ YES ☐NO _____

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURETELY 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 TO PERSONAL AND MEDICAL INFORMATION.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ **DATE:** _____