

Date: _____

Patient Name: _____ Prefers to be called _____

Sex: Male Female Birthdate: _____ Age: _____

Home Address: _____

City State Zip
Home #: _____

Mother/Father Information

Mother's name: _____ Birthdate: _____

Home#: _____ Cell#: _____

SS#: _____ Email: _____

Father's name: _____ Birthdate: _____

Home#: _____ Cell#: _____

SS#: _____ Email: _____

How would you like to be confirmed for your child's appointment? Phone Email Text Message

If text message who is your cell phone provider:

US Cellular Verizon Sprint AT&T T-Mobile Other _____

Person Responsible for Account

Mother Father Other (fill out below)

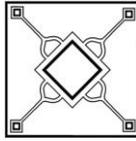
Name: _____ Birthdate: _____

Home Address: _____

City State Zip

Home#: _____ Cell#: _____

SS#: _____ Relationship: _____



Dental History

Previous / Present Dentist: _____ Date last seen: _____

Why did the child come to the dentist today? _____

Does the child have a history of cold sores or fever blisters? Yes No

Has the child ever had a serious/difficult problem associated with previous dental work? Yes No

Is the child's water fluoridated? Yes No

Is the child taking a fluoride supplement? Yes No

Has the child ever had any pain/tenderness in the jaw joint (TMJ/TMD)? Yes No

Does the child brush their teeth daily? Yes No

Does the child floss their teeth daily? Yes No

Allergies

Is the child allergic to any of the following? (please circle)

- | | | |
|--------------------|--------------|--------------|
| Aspirin | Erythromycin | Metals |
| Codeine | Jewelry | Penicillin |
| Dental Anesthetics | Latex | Tetracycline |

Please list any other drugs/materials that the child may be allergic to: _____

Does/did the child have any of the following habits:

Lip Sucking/Biting Yes No Nursing/ Bottle Habits Yes No

Nail Biting Yes No Thumb/Finger Sucking Yes No

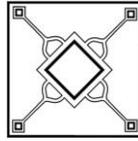
Medical History

Your child's current physical health is: Good Fair Poor

Child's Physician: _____

Phone #: _____

Date of last visit: _____



Is the child currently under the care of a physician? Yes No

If Yes, please explain:

Is the child taking any prescription drugs? Yes No

Is the child taking any over-the-counter drugs or herbal supplements? Yes No

Please list each one:

Has the child ever had any of the following diseases or medical problems?

- | | | | |
|---------------------------------------|--|--------------------------------|--|
| Abnormal Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | ADD/ADHD | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any hospital Stays | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any Operations | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Bones/Joints/Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer/Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Congenital Heart Defect | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions/Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Handicaps/Disabilities | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing Impairment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV+ / AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hospitalized for any reason | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic/Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sickle Cell Disease/Traits | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please list any serious medical problems that the child has ever had:

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

Signature

Date