

Welcome

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| | | |
|--|---|------------------------|
| Patient Information | | Date _____ |
| Patient's Name _____ <small>First Middle Last</small> | Nickname _____ | Sex _____ |
| Street Address _____ | Date of Birth _____ | Age _____ Weight _____ |
| Patient Social Security # _____ | Child Lives with: <input type="checkbox"/> Both parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ | |
| Names of brothers or sisters in practice _____ | School Name _____ | |
| Patient's Physician or Pediatrician Name _____ | Family Dentist _____ | |
| Whom may we thank for referring you? <input type="checkbox"/> Media <input type="checkbox"/> Doctor (name) _____ | <input type="checkbox"/> Friend (name) _____ | |
| <input type="checkbox"/> Website <input type="checkbox"/> Phone Book <input type="checkbox"/> Other _____ | | |

| | | |
|--|--|--|
| Responsible Party Information | | <input type="checkbox"/> Single <input type="checkbox"/> Separated |
| Name: _____ <small>First Middle Last</small> | Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced | |
| Residential Address _____ <small>Street City State Zip</small> | | |
| Mailing Address _____ <small>Street City State Zip</small> | | |
| How long at this address _____ | Home Phone _____ | Work Phone _____ |
| Previous Address (if less than 3 yrs.) _____ <small>Street City State Zip</small> | | |
| Social Security Number _____ | Birthdate _____ | Relationship to patient _____ |
| Employer _____ <small>(if self-employed, list name of business)</small> | Occupation _____ | No. Years Employed _____ |
| Spouse's Name: _____ | Relationship to Patient _____ | |
| Employer _____ <small>(if self-employed, list name of business)</small> | Occupation _____ | No. Years Employed _____ |
| Social Security Number _____ | Birthdate _____ | Work Phone _____ |
| Email Address _____ | Approved ID _____ | Issue Date _____ |

| | | |
|-------------------------------------|--|------------------------------|
| Dental Insurance Information | | |
| Policy Holder's Name _____ | Policy Holder's Soc. Sec. # _____ | Birthdate ____ / ____ / ____ |
| Insurance Co. _____ | Group No. _____ | Subscriber No. _____ |
| Insurance Co. Address _____ | Phone No. _____ | |
| Policy Holder's Employer _____ | Do you have other dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | |
|---|-------------------------------|--|
| Emergency Information | | |
| Name of nearest relative not living with you _____ | Phone No. _____ | |
| Address _____ <small>Street City State Zip</small> | Relationship to patient _____ | |

I understand that where appropriate, credit bureau reports may be obtained.

Signed _____ Date _____

Medical History

Does your child/teen have any of the following? Please circle.

| | | |
|-----------------------|-----------------------------|-----------------------|
| Y N Allergies | Y N Fainting | Y N Pregnancy/Nursing |
| Y N Anemia | Y N Hearing Disorder | Y N Rheumatic Fever |
| Y N Asthma | Y N Heart Disease | Y N Seizures/Epilepsy |
| Y N Autism | Y N Hepatitis | Y N Special Needs |
| Y N Bleeding Disorder | Y N Kidney or Liver Disease | Y N Speech Disorder |
| Y N Diabetes | Y N Mental Disorder | Y N AIDS/HIV |
| Y N Cold/Virus | Y N Nervous Disorder | Y N Other _____ |

My child was born: (please check) Less than 35 weeks 35-40 weeks 40+ gestation

Did you experience any problems during your pregnancy? Yes No If Yes, please describe: _____

Do any family members smoke around your child? Yes No

Has your child experienced any other physical or mental disorder that is not listed above? Yes No

If Yes, please describe: _____

Has any immediate family member had any of the above? Yes No If Yes, please describe: _____

Is your child allergic to any of the following drugs:

Y N Penicillin Y N Amoxicillin Y N Erythromycin Y N Codeine Y N Dental Anesthetic

Is your child allergic to any other drugs: Yes No If Yes, please list: _____

Is your child allergic to Latex, red dye or anything we need to be aware of? Yes No If Yes, list: _____

Is your child presently under the care of a physician for any illness? Yes No If Yes, please list: _____

List any drugs or medicines presently being taken: _____

Has your child ever been hospitalized? Yes No If Yes, please give reason and date(s) _____

Dental History

Do you want complete treatment for your child? Yes No

Why did you bring your child to see us today? _____

Is this your child's first visit to the dentist? Yes No Name of previous dentist: _____

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

If Yes, please explain _____

Date of last dental visit _____ For what service _____

Were any x-rays taken? Yes No If Yes, have x-rays been sent to our office? _____

How do you expect your child to behave in our office? _____

Y N Does your child brush his/her teeth daily?

Y N Do you assist child with tooth brushing?

Y N Is dental floss used? — How often? _____

Y N Is fluoride taken in any form? How: Y N — Vitamins Y N — Toothpaste Y N — Drinking Water

Y N Any mouth habits (thumbsucking, nail biting, mouth breather, nursing bottle habits, pacifier, etc.)

Y N Any injuries to mouth, teeth, head? Date(s) _____

Y N Has child ever had jaw joint pain or tenderness?

My child uses a bottle (please check one): no daytime nighttime.

My child uses a sippy cup (please check one): no daytime nighttime.

May we request release of your child's medical records? Yes No

Thank you for your help. If there is any information that you feel might be of value to us in the treatment of your child, please add it here: _____

I give my consent to needed dental treatment and the use of proper and acceptable methods to complete said treatment for my child, (child's full name) _____ . I accept responsibility for payment of services rendered.

Signed: _____ Date: _____
(Parent or Guardian)

Office use only: Doctor's Comments: _____