

PATIENT INFORMATION

Date _____

Patient's name _____

Last

First

Middle

Address _____

Street

City

Zip

Home Phone _____ Birthdate _____ Social Security # _____

Hobbies or Interests _____

Siblings/Ages _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____

Last

First

Middle

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____

Residence _____

Street

City

Zip

Mailing Address _____

Street

City

Zip

Home phone _____ Work phone _____

Cell/other phone _____ Email address _____

Spouse's Name _____ Relationship to Patient _____

Social Security # _____ Birthdate _____ Phone _____

Employer _____ Occupation _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____

Street

City

Zip

Phone _____

Parent's Signature _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

- Yes No Is your child taking any medication? _____
 - Yes No Does your child have a history of a major illness? _____
 - Yes No Has your child had any operations? _____
 - Yes No Is your child allergic to any medication? _____
 - Yes No Is your child allergic to any foods? _____
 - Yes No Is your child biologically related to you?*
- *We value the integrity of your family and understand this question may be a sensitive one for some families; please leave blank if you'd prefer to address this verbally and/or privately with your dentist.*

We welcome patients with special needs and complex medical conditions.
Please circle any of the medical conditions below that apply to your child

- | | | | |
|------------------------------|-------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Bone Disorders | Hepatitis/Liver problems | Radiation/Chemotherapy |
| ADD/ADHD | Congenital Heart Defect | HIV/AIDS | Rheumatic Fever |
| Anemia | Diabetes | Kidney problems | Special Needs |
| Arthritis | Epilepsy | Nervous Disorders | Tuberculosis |
| Asthma or Hayfever | GI Disorders | Pneumonia | |
| | Heart Murmur | Prolonged Bleeding | |

Are there any medical conditions not included above that you feel we should be aware of? _____

DENTAL HISTORY

- Previous Dentist _____ Date of last visit _____
- Yes No Do you have any special concerns about your child's teeth? _____
 - Yes No Is your child presently in any dental pain? _____
 - Yes No Has your child ever experienced any unfavorable reaction to dentistry? _____
 - Yes No Has your child ever lost or chipped any teeth? _____
 - Yes No Have there ever been any injuries to face, mouth, or teeth? _____
 - Yes No Does your child have any type of thumb or tongue habit? _____
 - Yes No Does your child snore or breathe through their mouth? _____
 - Yes No Does your child grind his/her teeth? _____
 - Yes No Are you aware that some appointments will be during school/work hours? _____

I have truthfully answered all the above questions and agree to inform this office of any changes in my child's medical or dental history. In addition, I authorize the doctor to perform a complete oral evaluation upon my child.

Parent's Signature: _____ Date: _____