Patient Information

Patient Name:_____ Nickname:_____Date:_____
Birthday:_____ Age:_____ Sex:_____ Social Security #:_____
Parent/Guardian Name:_____ Relationship to Patient:_____
Address:_____ City:_____ State:_____ Zip:_____
Home phone: _____ Cell Phone: _____ E-mail:_____

Responsible Party Information (Payment)

Name:_____ Sex:_____ Marital Status:_____(Married, Single)
Social Security #:_____ Birth Date:_____ E-mail:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Employer Name:_____ Occupation:_____
Work Address:_____ City:_____ State:_____ Zip:_____

Insurance Information

Name of Insured:_____ Birth Date:_____ Relationship to Patient:_____
Insured Address:_____ City:_____ State:_____ Zip:_____
Insurance Plan Name:_____ Group #:_____
Insured Social Security #:_____ ID#:_____
Insurance Plan Address:_____ City:_____ State:_____ Zip:_____

Referral Information

Whom may we thank for referring you to our practice?_____
(Another patient, Dental Office, Yellow Pages, Newspaper, School, Work, Other)

Health Information

Child's Physician:_____ Phone #:_____ Date of Last Exam:_____
History of Hospitalizations/Emergency Room Care (Why and When):_____
_____
Current Medications:_____
Allergies (Medication/Other):_____
Have you been told that your child should have antibiotics before dental visits?_____
Please mark if your child has been diagnosed and/or treated for any of the following:

- ☐ Blood Disorder/Anemia
- ☐ Immune Disorder/HIV/AIDS
- ☐ Cancer/Tumors
- ☐ Endocrine Disorders/Diabetes
- ☐ Seizures/Epilepsy
- ☐ Heart Disease/Murmur
- ☐ High Blood Pressure
- ☐ Bone/Joint Problems
- ☐ Kidney Disease
- ☐ Lung/Breathing Problem
- ☐ Liver Disease/Jaundice/Hepatitis
- ☐ Stomach/GI Disease
- ☐ Asthma/Reactive Airway
- ☐ Rheumatic Fever
- ☐ Cleft Lip & Palate
- ☐ Premature/Low Birth Weight
- ☐ Cerebral Palsy
- ☐ Autism Spectrum
- ☐ ADD/ADHD
- ☐ Mental/Cognitive Delay
- ☐ Psychiatric/Emotional Disorder
- ☐ Congenital Birth Defects
- ☐ Social Delay
- ☐ Behavioral Problems
- ☐ Speech Disorder
- ☐ Eating Disorder
- ☐ Hearing Loss
- ☐ Vision Problems
- ☐ Injuries to Face/Mouth
- ☐ Other:_____

Please elaborate on items circled:_____
_____

Dental History

Has your child ever been to the dentist? _____ Date of last dental visit?_____
Do you think your child will react well to dental treatment?_____
Does your child have any of the following oral habits?

- ☐ Thumb
- ☐ Finger
- ☐ Pacifier
- ☐ Lower Lip Sucking
- ☐ Tongue Thrust
- ☐ Bottle Feeding
- ☐ Demand Breast Feeding
- ☐ Mouth Breathing
- ☐ Other:_____

Does your child brush his/her teeth?_____ How often?_____
Does your child use dental floss?_____ How often?_____
Does your child use a fluoride toothpaste?_____Fluoride Rinse?:_____
Does your child use a fluoride supplement? (Include Dose):_____
Does your child snack between meals?_____ Types of snacks?_____
Does your child have any dental problems of concern? If yes, describe:_____