# PATIENT INFORMATION

PATIENT'S NAME _____

GENDER (M/F) _____ BIRTHDATE _____ SOCIAL SECURITY # (SSN) _____

ADDRESS _____ PHONE NUMBER _____

CITY _____ STATE _____ ZIP CODE _____

FATHER'S NAME _____ BIRTHDATE _____

SSN _____ MARITAL STATUS _____ CONTACT # _____

MOTHER'S NAME _____ BIRTHDATE _____

SSN _____ MARITAL STATUS _____ CONTACT # _____

How did you find out about our practice?

□ Dental Office □ Pediatrician Office □ Insurance Company □ Patient

□ Office Sign □ Yellow Pages □ Other? _____

## RESPONSIBLE PARTY INFORMATION
(If other than parents)

NAME _____

GENDER (M/F) _____ BIRTHDATE _____ SOCIAL SECURITY # (SSN) _____

ADDRESS _____ PHONE NUMBER _____

CITY _____ STATE _____ ZIP CODE _____

EMPLOYMENT INFORMATION

EMPLOYER _____ PHONE NUMBER _____

ADDRESS _____

## DENTAL INSURANCE INFORMATION

Primary Insurance
NAME OF SUBSCRIBER _____ ID# _____
EMPLOYER _____ ADDRESS _____
INSURANCE NAME _____ GROUP NUMBER _____
INSURANCE ADDRESS _____
_____

Secondary Insurance
NAME OF SUBSCRIBER _____ ID# _____
EMPLOYER _____ ADDRESS _____
INSURANCE NAME _____ GROUP NUMBER _____
INSURANCE ADDRESS _____
_____

(16.0922)

# DENTAL HISTORY

| | YES | NO |
|---|---|---|
| Were you referred to our office by a health care provider? If so, who referred you and what was the reason for referral | ☐ | ☐ |
| Is there any pain or other immediate dental problem? Please describe the area and nature of pain | ☐ | ☐ |
| Is this the first dental visit? What was the date, reason for visit, and treatment provided for previous dental appointment? | ☐ | ☐ |

Date of last full mouth or panoramic radiographs? _____
(please request prior dentist send copy to our office if less than 3 years ago)

| | | |
|---|---|---|
| Has your child had any unfavorable dental experience? | ☐ | ☐ |
| Do you expect your child to react unfavorably to this and/or future dental visits? Please explain any previous unfavorable dental experiences or negative expectations for current and future dental visits | ☐ | ☐ |

## DENTAL HOME CARE INFORMATION

| | | |
|---|---|---|
| Does your child brush 2 or more times per day? | ☐ | ☐ |
| Does your child floss at least once per day? | ☐ | ☐ |
| Does someone assist and/or inspect thoroughness of child's oral hygiene? | ☐ | ☐ |
| Is your child on fluoride vitamins or supplements? | ☐ | ☐ |

## MEDICAL INFORMATION AFFECTING DENTAL TREATMENT

| | | |
|---|---|---|
| Is there any medical precautions necessary for dental treatment (please explain) _____ | ☐ | ☐ |

## AUTHORIZATION

| | YES | NO |
|---|---|---|
| I am authorized as a parent or legal guardian to consent for treatment for this child | ☐ | ☐ |

Name of child _____
Authorizing Name _____
Authorizing Signature _____
Relationship to child _____

# MEDICAL HISTORY

Physician Name _____ Address _____ Phone_____

Date of last physical examination_____ Results _____

| | YES | NO |
|---|---|---|
| **GROWTH AND DEVELOPMENT:** | | |
| Any learning, behavioral, excessive nervousness, or communication problems? | ☐ | ☐ |
| Has any psychological counseling been recommended or received? | ☐ | ☐ |
| Any problems with physical growth? | ☐ | ☐ |
| **CENTRAL NERVOUS SYSTEM:** | | |
| Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness? | ☐ | ☐ |
| Any sensory (hearing, eye, glaucoma, etc.) disorders? | ☐ | ☐ |
| **CARDIOVASCULAR SYSTEM:** | | |
| Any history of congenital heart disease, heart murmur, or heart damage from rheumatic fever? | ☐ | ☐ |
| Has any heart surgery been done or recommended? | ☐ | ☐ |
| Any history of chest pains, high blood pressure, or stroke? | ☐ | ☐ |
| **HEMATOPOIETIC AND LYMPHATIC SYSTEMS:** | | |
| Any history of blood or blood products transfusion? | ☐ | ☐ |
| Any history of anemia, sickle cell disease, or hemophilia? | ☐ | ☐ |
| Any problems with bruising easily, frequent nosebleeds, or bleed excessively from small cuts? | ☐ | ☐ |
| **RESPIRATORY SYSTEMS:** | | |
| Any history of pneumonia, cystic fibrosis, asthma, emphysema, or difficulty in breathing? | ☐ | ☐ |
| Any history of tuberculosis (TB) | ☐ | ☐ |
| **GASTROINTESTINAL SYSTEM** | | |
| Any history of stomach or intestinal problems? | ☐ | ☐ |
| Any history of hepatitis or jaundice (other than at birth) or liver disease? | ☐ | ☐ |
| Any history of eating disorders or unintentional weight loss? | ☐ | ☐ |
| **GENITOURINARY SYSTEM:** | | |
| Any history of urinary tract infections, bladder or kidney problems? | ☐ | ☐ |
| Any history of venereal disease (syphilis, gonorrhea)? | ☐ | ☐ |
| Is the patient pregnant or possible pregnant? | ☐ | ☐ |
| **ENDOCRINE SYSTEM:** | | |
| Any history of diabetes? | ☐ | ☐ |
| Any history of thyroid disorders or other glandular disorders? | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| SKIN: | | |
| Any history of skin problems? | ☐ | ☐ |
| Any history of cold sores? | ☐ | ☐ |
| EXTREMETIES: | | |
| Any arthritis or other joint problems? | ☐ | ☐ |
| Any problems with muscle weakness or muscular dystrophy? | ☐ | ☐ |
| IMMUNIZATIONS | | |
| Are immunizations current? | ☐ | ☐ |
| Is there any immunosupressant conditions (AIDS, AIDS related complex, or HIV positive)? | ☐ | ☐ |
| ALLERGIES: | | |
| Any allergies to any medicine, local anesthetic, or material? | ☐ | ☐ |
| MEDICATIONS OR TREATMENTS | | |
| Are any medicine or drugs being taken? | ☐ | ☐ |
| Any history of radiation therapy, chemotherapy, or implant prosthesis? | ☐ | ☐ |
| HOSPITALIZATIONS | | |
| Any history of being hospitalized? | ☐ | ☐ |
| Are there any condition not listed above? | ☐ | ☐ |

Medication Dosage Times per day

Date

Reason

Please explain any conditions listed or any other information that our office should be aware of.

Name of person providing information

Relation to Patient

Date