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About Your Child

Child's Name: _____

Nickname: _____ □ Male □ Female

Birthday: ____/____/_____Age ____SS#_____

Does child live with □ Both Parents □ Mom □ Dad

□ Guardian □ Foster Parents □ Stepmother □ Stepfather

□ Other _____

Child's Address: _____

City: _____ State ____ Zip _____

If Child does not live with both parents, please provide addresses of both parents:

Mom: _____

City: _____ State ____ Zip _____

Dad: _____

City: _____ State ____ Zip _____

Who Is Accompanying The Child Today?

Name: _____

Relation to Child: _____

Name of Person with Legal Custody of the Child:

_____

How Did You Hear About Us?

_____

Whom May We Thank For Referring Your Child?

_____

Other Family Members Seen By Us:

_____

Parent's Information

Mother's Name: _____DOB _____/_____/_____

Mother's Employer: _____SS# _____

Father's Name: _____DOB _____/_____/_____

Father's Employer: _____SS# _____

Telephone Numbers & E-mail

Home #: _____

Mom's Work #:_____

Mom's Cell #:_____

Dad's Work #:_____

Dad's Cell #:_____

Primary E-mail: _____

Emergency Contact (other than Parent/Guardian):

Name: _____

Phone #: _____

Relation to patient: _____

Dental Insurance

□ YES □ NO

Primary Insurance Company: _____

Group Name/#: _____

ID Number: _____

Secondary Insurance Company: _____

Group Name/#: _____

ID Number: _____

Who is the insurance Policy Holder?

_____

Patient Name: _____

Dental History

Has your child ever been to the dentist? □ YES □ NO Name of Dentist:_____
Date of last visit: _____ Date of last X-Rays (if known):_____
Any current dental complaints? _____
Has the child ever had a problem associated with previous dental work? □ YES □ NO Specify if yes: _____
_____
Who brushes your child's teeth? □ Child □ Child/Parent □ Parent When are teeth brushed? □ Morning □ Night □ After Meals
□ YES □ NO Is your child's water fluoridated?
□ YES □ NO Is your child taking a fluoride supplement? If yes, what? _____
□ YES □ NO Is fluoridated toothpaste used?
□ YES □ NO Are your child's teeth flossed? If yes, how often: _____
□ YES □ NO Has your child ever injured his/her teeth or gums? Explain: _____
□ YES □ NO Does your child's jaw make noise and is pain associated with the sounds?
□ YES □ NO Does your child wear a mouth guard for sports?
□ YES □ NO Does either parent have a history of dental caries (cavities)?
□ YES □ NO Does the child have siblings with dental caries (cavities)?

Oral Habits

Was your child: □ Bottle Fed □ Breast Fed At what age was it stopped? _____
Does/Did your child sleep with a bottle/sippy cup? □ YES □ NO
What is/was fed from the bottle? □ Milk □ Juice □ Formula □ Kool Aid □ Pop □ Water □ Other _____
Estimated Daily Intake in Cups: Juice ____ Cups Milk ____ Cups Pop ____ Cups
How often does your child eat snacks? _____ times/day Frequent snacks: _____
□ YES □ NO Thumb/Finger Sucking or Pacifier
□ YES □ NO Lip Sucking/Biting
□ YES □ NO Nail Biting
□ YES □ NO Does your child grind his/her teeth? When? _____

Patient Health History

Please indicate if your **child** has any history of the following and write in details (dates, etc.) below

Y N Heart Surgery	Y N Intellectual Disability	Y N Diabetes	Y N Hepatitis A, B, or C
Y N Congenital Heart Defect	Y N Physical Disability	Y N Asthma	Y N Liver/GI Disease
Y N Rheumatic Fever	Y N Premature Birth	Y N Tuberculosis	Y N Kidney Disease
Y N Shunts	Y N Congenital Birth Defect	Y N Anemia	Y N Immune Disorder
Y N Autism	Y N Cleft Lip/Palate	Y N Hemophilia	Y N Cancer/Tumors
Y N ADD/ADHD	Y N Speech/Hearing	Y N Sickle Cell Disease	Y N HIV/AIDS
Y N Seizures/Epilepsy	Y N Recurrent Headaches	Y N Excessive Bleeding	Y N Cold Sores
Y N Emotional/School Problems	Y N Earaches/Ear Infections	Y N Transfusions/Blood Dyscrasias	Y N Other _____

Please elaborate on YES items: _____
_____

Please list any medications your child is currently taking: _____

Is your child allergic to any of the following: □ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Latex □ Metal
□ Acrylic □ Milk/Dairy □ Nuts □ Other _____
Has your child ever been hospitalized or had a major operation? □ YES □ NO _____
Did the birth mother or child have any problems during pregnancy or birth? □ YES □ NO _____
Did the birth mother take any medications during pregnancy? □ YES □ NO _____

Do you consider your child to be: □ Advanced in the learning process □ Progressing normally □ Slow in the learning process

What grade is your child in? _____ What school does your child attend? _____

Reason for your child's visit? _____

I hereby certify that the information and statements made on this form are true and correct to the best of my knowledge and belief.

_____
Parent/Legal Guardian Signature