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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:

Name: ____________________________________

Phone #: __________________________________

Relation: __________________________________

Dental Insurance

□ YES □ NO

Primary Insurance Company: ___________________________

Group Name/#: ______________________________________

ID Number: ____

Secondary Insurance Company: _________________________

Group Name/#: ______________________________________

ID Number: ____

Who is Responsible for Payment on Account?

____

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