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Patient Information

Patient's Full Name: _____ Nickname: _____ □ Male □ Female

Date of Birth: ____/____/_____ Age ____ Address: _____

City: _____ State ____ Zip _____ Other Family Members Seen By Us: _____

Who Is Accompanying The Patient Today?

Name: _____ Relationship to Patient: _____

Name of Person with Legal Custody of the Patient: _____

Parent Information

Parent 1 Full Name: _____ DOB _____/_____/_____

Parent 1 Phone Number: Home #:_____ Cell # _____ Work # _____

Parent 1 Address (if different than above): _____ City: _____State: ___ Zip: _____

Parent 1 Occupation/Employer: _____

Parent 2 Full Name: _____ DOB _____/_____/_____

Parent 2 Phone Number: Home #:_____ Cell # _____ Work # _____

Parent 1 Address (if different than above): _____ City: _____State: ___ Zip: _____

Parent 2 Occupation/Employer: _____

Patient lives with: □ Both Parents □ Parent 1 □ Parent 2 □ Other _____

Dental Insurance

Primary Insurance Policyholder Name: _____ DOB _____/_____/_____

Relationship to Patient: _____ Insurance Company: _____

If Employer Plan, Policyholder Employer: _____ Group Number: _____

Insurance ID Number **OR** Social Security Number Used to File Claims: _____

Secondary Insurance Policyholder Name: _____ DOB _____/_____/_____

Relationship to Patient: _____ Insurance Company: _____

If Employer Plan, Policyholder Employer: _____ Group Number: _____

Insurance ID Number **OR** Social Security Number Used to File Claims: _____

Communication

Primary phone number to use for text appointment reminders: _____ □ I decline text appointment reminders

Primary email address to have on file: _____ Whose email is this? _____

Patient's Doctor/Pediatrician: _____

Patient's Emergency Contact Name (other than Parent/Guardian): _____ Phone number: _____

Relationship to patient: _____

How Did You Hear About Us? _____

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