

PATIENT INFORMATION

Child's Name (First/Middle/Last) _____
Birth Date _____ Social Security# _____ Male Female
Address: _____ Home#: _____
City: _____ State: _____ Zip: _____
Has any member of your family been treated in our office? No Yes
Has your child been treated by another dentist? No Yes, Dr. _____
Who may we thank for referring you to our office? _____

PARENT/GUARDIAN INFORMATION

Relationship to patient: _____	Relationship to patient: _____
Name (First/Middle/Last) _____	Name (First/Middle/Last) _____
DOB: _____ SS#: _____	DOB: _____ SS#: _____
Drivers License #: _____	Drivers License #: _____
Address: _____	Address: _____
City/State/Zip _____	City/State/Zip _____
Home#: _____	Home#: _____
Cell/Work#: _____	Cell/Work#: _____
Employer: _____	Employer: _____
Email: _____	Email: _____

INSURANCE INFORMATION

Please notify the office of any insurance changes at each visit that may affect your account. As a courtesy, we will bill your insurance company on your behalf. You are responsible for any remaining balance.

Subscriber (First/Middle/Last) _____	Subscriber (First/Middle/Last) _____
DOB: _____ ID#: _____	DOB: _____ ID#: _____
Primary Insurance Co.: _____	Secondary Insurance Co.: _____
Phone#: _____	Phone#: _____

EMERGENCY CONTACT Person to contact in case of an emergency other than parent/guardian.

Name: _____ Phone#: _____ Alt#: _____
Address/City/State: _____

AUTHORIZATION

I hereby authorize direct payment to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I understand that any previous balances must be paid before future care will be given. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge and may be used to contact me at anytime.

SIGNATURE OF RESPONSIBLE PARTY: Relationship to patient: _____

X _____ Date: _____

Last Name: _____ First Name: _____

DENTAL AND MEDICAL HISTORY QUESTIONNAIRE (Please answer every question.)

- Yes No 1. Has the child had any unusual or unpleasant experiences in a dental or medical office?
- Yes No 2. Has the child had any injuries to the face, mouth or teeth?
- Yes No 3. Was the child breast fed? How long? _____
- Yes No 4. Does the child have any oral habits such as thumb sucking or sleeping with a bedtime bottle?
- Yes No 5. Is there a chief concern regarding the child's oral health? Explain: _____
- Yes No 6. Is the child presently in good health?
- Yes No 7. Are the child's immunizations current? Child's Physician: _____
- Yes No 8. Has the child been in a hospital or had surgery? Describe: _____
- 9. Please describe any current medical treatment, pending surgery, recent injury or any other information:

- Yes No 10. Is the child taking any medications at this time? List: _____
- _____
- Yes No 11. Does the child attend any class or school?
- Yes No 12. Does the child have any abnormal behavior? Describe: _____
- Yes No 13. Were there any problems during pregnancy, delivery or during the child's first year of life?
- Yes No 14. Has the child had any unusual reaction or allergy to medications such as penicillin, aspirin, or local anesthetics?
- Yes No 15. Does the child have a history of allergies? List: _____
- Yes No 16. Is the child pregnant?
- 17. Do you obtain your drinking water from A Well Bottled Water A Water Purifier City Water

MEDICAL DIAGNOSIS HISTORY

- | | | |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No ADD/ADHD | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No Ear Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No Learning Disability |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Unusual Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No Nutritional Problem |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Autism/SID | <input type="checkbox"/> Yes <input type="checkbox"/> No Faintness/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Behavior Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Sickle Cell Disease/Trait |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Birth Defects | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No Speech Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer or Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cerebral Palsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cognitively Impaired | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Vision Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Convulsions/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No High Fevers | <input type="checkbox"/> Yes <input type="checkbox"/> No Other |

I have updated my child's health history and understand I am responsible for any out of pocket costs. Please sign and date on line #1 for your first visit and next available line at each recall visit.

- | | |
|------------------|-------------------|
| 1. _____
Date | 6. _____
Date |
| 2. _____
Date | 7. _____
Date |
| 3. _____
Date | 8. _____
Date |
| 4. _____
Date | 9. _____
Date |
| 5. _____
Date | 10. _____
Date |