



**PATIENTS INFORMATION**

Name \_\_\_\_\_  Male  Female SS# \_\_\_\_\_  
 Pediatrician \_\_\_\_\_ Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Name(s) and Age(s) of siblings in our practice \_\_\_\_\_  
 Referred to us by \_\_\_\_\_ Family Dentist \_\_\_\_\_

**CONFIRMING INFORMATION**

Which is the best contact number?  home: \_\_\_\_\_  cell: \_\_\_\_\_  
 Can we call you at work?  yes  no If yes, work number \_\_\_\_\_ Name \_\_\_\_\_  
 E mail Address to confirm appointment \_\_\_\_\_

**PARENT OR LEGAL GUARDIAN INFORMATION**

Person responsible for payment \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Father or legal guardian \_\_\_\_\_ Mother or legal guardian \_\_\_\_\_  
 Address \_\_\_\_\_ Address \_\_\_\_\_  
 City \_\_\_\_\_ City \_\_\_\_\_  
 Zip \_\_\_\_\_ Phone \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Employed by \_\_\_\_\_ Employed by \_\_\_\_\_  
 Marital Status  Married  Widowed  Separated  Divorced  Single

**PATIENT MEDICAL HISTORY**

Is your child adopted? Yes No Foster child? Yes No  
 Is your child in poor health? Yes No If yes, explain \_\_\_\_\_  
 Is your child under the care of a physician? Yes No If yes, explain \_\_\_\_\_  
 Has your child ever had surgery Yes No If yes, explain \_\_\_\_\_  
 Has your child ever had complications following dental treatment? Yes No If yes, explain \_\_\_\_\_  
 Is surgery contemplated? Yes No If yes, explain \_\_\_\_\_  
 Does your child have any health problems that need further clarification? Yes No If yes, explain \_\_\_\_\_  
 List all medications your child is taking \_\_\_\_\_

Does your child have/ever had any of the following? Please check those that apply

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Food Allergy _____ |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Physically Impaired  | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> ADHD/ADD           | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Red Dye Allergy    |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Tumors              | <input type="checkbox"/> Due date: _____      | <input type="checkbox"/> Latex Allergy      |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Depression           | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Transfusion  | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Rheumatic Fever      |   |
| <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Ulcers               | OTHER:                                      |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Stomach Problems     | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stroke               |   |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Tuberculosis         |   |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders    | <input type="checkbox"/> Acid Reflux          |   |
|   |  | <input type="checkbox"/> Sickle Cell Trait    |   |
|   |  | <input type="checkbox"/> Sickle Cell Anemia   |   |

**DENTAL HISTORY**

	YES	NO
Is this the child's first visit to a dentist?	_____	_____
Do you have fluoridated water at home?	_____	_____
Have there been any injuries to teeth?	_____	_____
If yes, please explain _____		
Has child had any unfavorable dental experience?	_____	_____
Does child suck thumb or finger?	_____	_____
Has child have any other habits?	_____	_____
Does child still take bottle or breastfeed?	_____	_____
Does parent help with oral hygiene?	_____	_____
Does child have a TOOTHACHE?	_____	_____

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_