

Demographic Information

Patient _____ Date _____

Name child would like to be called _____

Birthday _____ Age _____ Sex _____ Home Phone _____

Home Address _____
street town zip code

Names (and ages) of other children in family _____

School _____ Grade _____

Parent/Guardian _____

Mother's Name _____ E-mail _____

Mother's SS# _____ DOB _____

Mother's Address _____ Cell Phone _____

Mother's Employer Phone _____

Father's Name _____ E-mail _____

Father's SS# _____ DOB _____

Father's Address _____ Cell Phone _____

Father's Employer Phone _____

Who has legal custody of patient? _____

Person responsible for payment of account _____

Dental Insurance: **Yes** **No** Subscriber's Name _____

Employer _____ Insurance Company _____

Claims Address _____

Insurance phone _____ Group No _____

Secondary Dental Insurance: **Yes** **No** Subscriber's Name _____

Employer _____ Insurance Company _____

Claims Address _____

Insurance phone _____ Group No _____

Whom may we thank for referring you to us? _____

What is the reason for your child's dental visit? _____

Health History

Yes **No** Is your child in good health?

Name of child's physician _____ Date of last physical exam _____

Yes **No** Has your child ever had a health problem? _____

Yes **No** Has your child ever been hospitalized?

Please give reason and dates _____

Yes **No** Is your child allergic to anything?

Yes **No** Is your child currently taking any medications?

Please give medication and reason _____

Yes **No** Were there any problems at birth? _____

Please check if your child has been treated for any of the following:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Heart disease/murmur | <input type="checkbox"/> Bleeding/transfusions | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood dyscrasias |
| <input type="checkbox"/> Liver/GI disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental delays |
| <input type="checkbox"/> Speech/hearing | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Physical delays |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Congenital birth defects | <input type="checkbox"/> Personality/social | <input type="checkbox"/> Other problems |
| <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Recurrent headaches | <input type="checkbox"/> Frequent infections | |

Please elaborate on any items checked: _____

Yes No Does your child see a specialist for any health problems?

Please give reason, doctor and phone number _____

Do you consider your child to be: advanced in the learning process
 progressing normally
 slow in the learning process

Was your child: breast fed bottle fed At what age was it stopped? _____

Dental History

Yes **No** Has your child ever been to the dentist?

Name of dentist and date _____

Yes **No** Has your child experienced any unfavorable reaction from previous dental care?

Explain _____

Yes **No** Does your child suck a finger, thumb or pacifier?

Yes **No** Does your child have pain with chewing, yawning, or wide opening?

Yes **No** Does your child's jaw make noise and is pain associated with the sounds?

Please check if your child is having problems with any of the following:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Toothache | <input type="checkbox"/> Teeth Sensitive |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Gum Infections | <input type="checkbox"/> Color of teeth |
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Jaw Sounds | <input type="checkbox"/> Other |

Comments: _____

Fluoride History

Yes **No** Does your child use a fluoride toothpaste?

Yes **No** Do you give your child any other form of fluoride? What? _____

Signature _____ **Date** _____