## PATIENT INFORMATION

**Date:** _____

Patient's Name: _____
Name child likes to be called | Last | First | Middle

Address: _____
Street | City | State | Zip

Birthdate: _____/_____/_____ Age: _____ Sex: M / F

S.S. #:_____-_____-_____ School: _____

Name of Legal Guardian: _____

Brothers/Sisters seen by us: _____

Previous Dentist: _____ Date Last Seen: _____

Who may we thank for referring you to our office? _____

**********GUARDIAN INFORMATION**********

**Parent/Guardian:** _____ Marital Status: S / M / D / W
Last | First | Middle

Residence: _____
Street | City | State | Zip

Mailing Address (if different than above): _____
Street | City | State | Zip

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

E-Mail Address: _____

S.S. #: _____-_____-_____ Birthdate: _____/_____/_____Relationship to patient: _____

Employer: _____ Occupation: _____ # Years Employed: _____

**Parent/Guardian:** _____
Last | First | Middle

Mailing Address (if different than above): _____
Street | City | State | Zip

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

E-mail Address: _____

S.S. #: _____-_____-_____ Birthdate: _____/_____/_____Relationship to patient: _____

Employer: _____ Occupation: _____ # Years Employed: _____

With whom does the child live?_____

**********DENTAL INSURANCE INFORMATION**********

Insured's Name: _____Insured's Address_____
Street | City | State | Zip

Relationship to Patient:_____ Birthdate: _____/_____/_____ S.S. #:_____-_____-_____

Insured's Phone Number: _____ Insurance Co. Phone Number:_____

Insured's Employer: _____ Insurance Company: _____

**Do you have double coverage:** Yes _____ No _____ **If yes:**

Insured's Name: _____Insured's Address_____
Street | City | State | Zip

Relationship to Patient:_____ Birthdate: _____/_____/_____ S.S. #:_____-_____-_____

Insured's Phone Number: _____ Insurance Co. Phone Number:_____

Insured's Employer: _____ Insurance Company: _____

**********EMERGENCY CONTACT INFORMATION**********

Name of nearest relative not living with you: _____

Relationship to patient: _____ Phone: (____)_____

Complete Address: _____ Cell Phone: (____)_____
Street | City | State | Zip

# DENTAL AND MEDICAL HISTORY

Why did you bring the child to the dentist today? _____
Has the child had a bad previous dental experience? _____
Explain: _____
Is the child drinking fluoridated water? _____
Does the child take fluoride supplements? _____
Does the child brush his/her teeth daily? _____ Number of times? _____
Does an adult assist with brushing daily? _____ Number of times? _____
Is the child currently under the care of a physician? _____
For what problem? _____
Child's physician: _____
Address City State Zip
Physician's office phone number: (____)_____-_____
Date of last visit to physician? _____
Please describe the child's current physical medical condition (poor, good, etc.): _____
Please list all drugs/medicines the child currently takes: _____
_____
Is the child allergic to anything (medicine, dust, pollen)? _____
Please list: _____
_____

Does the child have or has he/she EVER had any of the following medical problems? Please check **ALL** that apply.

- □ Heart Murmur / Condition
- □ Cancer
- □ Chemotherapy / Radiation Treatment
- □ Abnormal bleeding / Hemophilia
- □ Rheumatic Fever
- □ HIV positive / AIDS
- □ Asthma / Breathing problem
- □ Hepatitis
- □ Tuberculosis / TB
- □ Anemia
- □ Blood Transfusion / Received Blood Products
- □ Congenital Heart Defect
- □ Convulsions / Epilepsy
- □ Diabetes
- □ Allergies
- □ Hearing / Speech / Vision disorder
- □ Operations
- □ Any hospital stays
- □ Kidney / Liver problems
- □ Handicaps / Disabilities
- □ Cerebral Palsy
- □ Other: _____
_____

Please tell us about any of these conditions:

_____
_____

Does the child have any of the following habits?

- □ Thumb / Finger Sucking / Pacifier Use
- □ Nail Biting
- □ Use a "sippy-cup"
- □ Lip sucking / Biting
- □ Nursing bottle habits
- □ Mouth breather / Snorer

***OUR OFFICE IS COMMITED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.***

I understand that the information I have given is correct to the best of my knowledge; that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need after these services are explained to me.

Signature of parent/guardian _____ Date _____