

ABOUT YOUR CHILD

Today's Date _____

Child's Name: _____

Nickname: _____

Sex: Male Female (circle one)

Age: _____ Birth date: _____

Social Security #: _____

Home address: _____

Home #: _____ Grade: _____

School: _____

Parent/Guardian: _____

Child's Favorite/Sport/Interest/Hobby/ Toy:

Whom may we thank for referring you?

ABOUT YOU

Your Name: _____

Relationship to child: _____

Home # & address if different: _____

Driver's License #: _____

SS#: _____

Occupation: _____

Employer: _____
Employer's address: _____

Work #: _____ Ext. _____

Responsible Party: _____

Nearest Relative: _____
Address & Phone#: _____

Preferred Contact # _____

DENTAL INSURANCE

PRIMARY

Dental Ins. Co. _____

Address: _____

Phone #: (8____) _____ - _____

Group #: _____

Insured ID #: _____

Relationship to child: _____

Insured Address: _____

Work #: _____

SS#: _____ DOB _____

Employer: _____

SECONDARY

Dental Ins. Co. _____

Address: _____

Phone #: (8____) _____ - _____

Group #: _____

Insured ID #: _____

Relationship to child: _____

Insured Address: _____

Work #: _____

SS#: _____ DOB _____

Employer: _____

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DENTAL HISTORY

Has your child been to the dentist before? _____
Date of last visit: _____ For what service? _____

	Circle One	
Any unhappy dental experiences?	YES	NO
Any injuries to mouth or head?	YES	NO
Any mouth habits- thumbsucking, nail biting, mouth breathing, nursing bottle		
Habits, pacifer, etc?	YES	NO
Unusual speech habits?	YES	NO
Lost teeth?	YES	NO
Have missing teeth been replaced?	YES	NO
Orthodontic appliance worn now or ever before?	YES	NO
Does child brush his/her teeth daily?	YES	NO
Do you assist your child with tooth brushing?	YES	NO
How often? _____		
Is dental floss used?	YES	NO
How often? _____		
Are disclosing tablets used?	YES	NO
Is fluoride taken in any form?	YES	NO
Do you desire complete dental service for the child?	YES	NO

Does child need to be premedicated before dental treatment? YES NO
Child's attitude toward dentistry? _____

Please rate child's dental health Good Fair Poor
Circle One

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MEDICAL HISTORY

Child's Physician _____
Address: _____

Phone: _____

Date of last visit: _____
Please rate your child's medical health:

Good Fair Poor
Circle One

Is child under care of physician now? YES NO
Is child taking prescription drugs? YES NO

Is there excessive bleeding when cut? YES NO
Has child ever been hospitalized? YES NO

Has child ever had surgery? YES NO

Is child allergic to penicillin or any drug? YES NO

Other allergies: food, pollen, animals, dust, etc.
YES NO

Does child have good coordination? YES NO

Are there emotional problems? YES NO

Has your child ever had any history of or difficulty with any of the following?

Please circle

Anemia	Fainting	Measles
Asthma	Hearing	Mononucleosis
Bladder	Heart	Mumps
Cerebral Palsy	HIV/AIDS	Rheumatic Fever
Chicken Pox	Hyperactive	Thyroid
Chronic Sinus	Kidney	Tuberculosis
Convulsions	Liver	Venereal Disease
Diabetes	Malignancies	Other _____
Epilepsy	Mastoid	_____

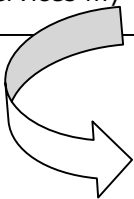
Does child have any other disease, condition, or problem not listed above? _____ If so please explain: _____

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In the event of an emergency, who should we contact? Name: _____
Relationship: _____ Phone: _____
2nd Phone: _____

May we request release of your child's medical records for our reference? _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in strictest 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.



The parent or guardian who presents the child for treatment is responsible for payment at the time of service.

Signature of Parent or Guardian

Date