Patient Information

Please assist us by answering all of the questions. This confidential information is important for our records in evaluating and treating your child.

Patient's Name_____ Male or Female
Last First Initial Nickname

Age_____Patient's Birthday_____/_____/_____School_____Grade_____

1. Who is Child's legal guardian?_____Relationship:_____
2. Who does child live with?_____Relationship:_____
3. Reason for this visit _____
4. Referred to our office by_____

Please list the first names of all brothers and sisters, and their ages:

_____

Has a member of your family been a patient in this office before?……...Yes No

Family Record

Residence_____Telephone ( ) -
Address City Zip

Father/Guardian's name_____ Date of Birth____/____/____Cell Phone:( ) -
Last First Initial

Address(If Different)_____E-mail address_____
Address City Zip

Occupation_____Employed by_____

Business address_____Telephone ( ) -
Address City Zip

Mother/Guardian's name_____Date of Birth____/____/____Cell Phone:( ) -
Last First Initial

Address(If Different)_____E-mail address_____
Address City Zip

Occupation_____Employed by_____

Business Address_____Telephone ( ) -
Address City Zip

Can our office contact parents/guardian via e-mail? .....Yes No

Medical History *(Please circle 'Y' or "Yes", 'N' or "No" answer all questions):*

Childs physician_____City_____Telephone ( ) -

Date last saw physician_____
Month / Year

1. Is your child presently under the care of a physician for any medical problem or condition?..Yes No What?_____
2. Is your child currently taking any medication?….Yes No What?_____
3. Does your child have/had any of the following:

*Y / N Diabetes	*Y / N Seizures	*Y / N Heart Trouble	*Y / N Liver Involvement	*Y / N HIV Related Complex
*Y / N Asthma	*Y / N Allergies	*Y / N Drug sensitivity	*Y / N Rheumatic fever	*Y / N Acquired immune
*Y / N Epilepsy	*Y / N Hepatitis	*Y / N Brain Injury	*Y / N Kidney Involvement	Deficiency Syndrome
*Y / N Murmurs	*Y / N Convulsions	*Y / N Blood disorders	*Y / N Latex Allergy	*Y / N Other:_____

4. Does your child have any type of allergies (food,medication,latex etc)…..Yes No What?_____
5. Has your child ever been hospitalized or had surgery……Yes No
6. Is your child emotionally disturbed, retarded, handicapped, autistic or have any type of learning disabilities?…….Yes No
7. Is there any other medical history or problem you feel should be brought to our attention….Yes No What?_____

Dental History

1. Is this your child's first dental visit?……...Yes No
   Previous Dentist_____Telephone ( ) -
   City Date of last visit
   Why are you changing dentist?_____
2. Has your child had an unfavorable experience in a previous dental (or medical) office?.....Yes No
3 Have there been any injuries to your child's teeth or jaws-falls, blows, chips, etc……Yes No
4. Does your child receive fluoride vitamins, tablets, water, etc……Yes No
5. Name of family dentist_____Telephone ( ) -

Authorization and Financial Responsibility

1. Is your child covered by a dental insurance plan……Yes No

Name of insured person_____ Social Security # - - Group number_____ Insurance Company_____

2.Is your child covered by a secondary dental insurance plan……Yes No

Name of insured person_____ Social Security # - - Group number_____ Insurance Company_____

3. If family not living together, person to be responsible for child's account_____

I HERBY AUTHORIZE THE DENTIST(S) IN CHARGE OF THE CARE OF MY ABOVE NAMED CHILD TO PERFORM ANY AND ALL TREATMENT AND CONSENT TO SUCH METHODS, DRUGS AND AGENTS AS MAY BE INDICATED IN CONNECTION WITH HIS/HER DENTAL CARE. THIS CONSENT SHALL REMAIN IN EFFECT UNTIL CANCELLED.

Signature_____ Relationship to child _____ Date_____

PLEASE NOTE: Payment is expected for service rendered at the time of the first visit.

Dr_____Date_____