

PATIENT INFORMATION

Child's Name _____ Date _____
Home Address _____ Phone _____
Sex [] M [] F Age _____ Birth Date _____ Nickname _____
Names and Ages of Brothers and Sisters _____
Hobbies, Pets, Favorite TV Shows, etc. _____
Person Responsible for this Account _____ Email _____
Whom may we thank for referring you? _____

DENTAL HISTORY

Reason for this visit (1st examination, check-up, toothache, etc.) _____

Has your child ever had an injury to the mouth, teeth or jaws (fall, blow, etc.)? _____
How long since last visit to a dentist? _____
Was the dental experience pleasant or unpleasant? _____
If unpleasant, how did he/she react? _____
Did he/she object to anything in particular? _____
Does your child have any history of thumb or lip sucking, pacifier, nail or lip biting? If yes, please explain:

Does your child use fluoride toothpaste? _____
Has your child ever taken fluoride supplements or vitamins with fluoride? _____

MEDICAL HISTORY

Child's physician/pediatrician _____ City _____ Phone _____
Is your child in good health? _____ Is your child taking any medications? _____
Is your child allergic to any medications? _____ General allergies? _____
Any history of cerebral palsy, seizures, fainting, or loss of consciousness? No Yes
Any sensory disorders? (Seeing, Hearing, Sensory Integration Disorder) No Yes
Has your child been diagnosed with PDD, autism, ADHD or ADD? No Yes
Any history of congenital heart disease, heart murmur or rheumatic fever? No Yes
Has any heart surgery been done or recommended? No Yes
Has your child ever had a blood transfusion? No Yes
Any history of anemia or sickle cell disease? No Yes
Does your child bruise easily or bleed excessively from small cuts? No Yes
Any history of pneumonia, cystic fibrosis, asthma, or difficulty breathing? No Yes
Any history of stomach, intestinal, kidney or liver problems? No Yes
Any history of hepatitis? No Yes
Any history of diabetes? No Yes
Any history of thyroid disease or other glandular disorders? No Yes
Has your child ever been hospitalized? No Yes
(If yes, please explain) _____
Is your child up to date with immunizations? (DPT,IPV,MMR,Hib,HepB) No Yes
Any additional or related problems? _____

INSURANCE

Father's/Guardian Name:	Mother's/Guardian Name:
Address (if different from Patient's):	Address (if different from Patient's):
Home Phone _____ Work Phone _____	Home Phone _____ Work Phone _____
Employer:	Employer:
Soc Sec# _____ Birthdate _____	Soc Sec# _____ Birthdate _____
Do you have dental insurance for minor Child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have dental insurance for minor Child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Plan Name:	Plan Name:
Plan Phone Number:	Plan Phone Number:
Plan Address:	Plan Address:
Plan Group Number:	Plan Group Number:
Plan Policy Number:	Plan Policy Number:

CONSENT:

1. The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor for a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. To the best of my knowledge, the above information is complete and accurate. I understand that even though I may have some type of dental insurance coverage, I am responsible for payment services rendered. I authorize release of any information to my insurance company related to my dental claims.

Parent/Guardian Signature	Date	Dentist Signature	Date
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DENTIST'S COMMENTS:

Medical consultation recommended? No ___ Yes ___ Date Requested _____
 Purpose for consultation: _____

SEMIANNUAL REVIEW OF MEDICAL-DENTAL HISTORY: If history remains essentially unchanged, sign below:

Parent/Guardian Signature	Date	Dentist Signature	Date
Parent/Guardian Signature	Date	Dentist Signature	Date
Parent/Guardian Signature	Date	Dentist Signature	Date