

PATIENT INFORMATION

DATE _____

CHILD'S FULL NAME _____ NICKNAME _____ PHONE (____) _____

STREET ADDRESS _____ AGE _____ BIRTH DATE _____

CITY/STATE/ZIP _____

MOTHER'S NAME _____ E-MAIL _____

MOTHER'S EMPLOYER _____ OCCUPATION _____ BUS. PHONE (____) _____

FATHER'S NAME _____ E-MAIL _____

FATHER'S EMPLOYER _____ OCCUPATION _____ BUS. PHONE (____) _____

PHYSICIAN'S NAME _____ CITY _____ PHONE (____) _____

PREVIOUS DENTIST _____ WHO REFERRED YOU? _____

IN CASE OF EMERGENCY, WHO SHOULD BE CONTACTED (OTHER THAN PARENT OR GUARDIAN)?

NAME/ADDRESS/PHONE _____

NAME AND AGES OF OTHER CHILDREN IN FAMILY _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE _____ SECONDARY DENT. INS. _____

GROUP#/EMPLOYER _____ GROUP #/EMPLOYER _____

SUBSCRIBER NAME _____ SUBSCRIBER NAME _____

DATE OF BIRTH _____ SOC.SEC.# _____ DATE OF BIRTH _____ SOC.SEC.# _____

CHILD'S HISTORY

Circle **YES** or **NO**

YES NO 1. Does your child have routine medical examinations?

YES NO 2. Is your child under medical care for a problem now?

YES NO 3. Is your child taking any medications now? Please list _____

YES NO 4. Has your child ever been seriously ill?

YES NO 5. Has your child ever taken antibiotics (penicillin, etc.)?

YES NO 6. Does your child have any allergies?

YES NO 7. Has your child visited a dentist before?

YES NO 8. Has your child seen an orthodontist? Who? _____

YES NO 9. Does anyone in your family have congenitally missing teeth?

YES NO 10. Does your child have any of the following habits?

_____ Tongue thrusting _____ Lip biting _____ Nail biting
_____ Mouth breathing _____ Thumb or finger sucking

YES NO 11. Does your child brush his/her teeth? How often? _____

If there is any medical or dental problem which is of special concern to you, or if you can provide any additional information which will help in the care of your child, please indicate below. Thank you!

I authorize routine and emergency care for my child.

Parent or legal guardian _____ Date _____

