

PATIENT INFORMATION

DATE _____

FULL NAME _____ PHONE (____) _____

STREET ADDRESS _____ AGE _____ BIRTHDATE _____

CITY/STATE/ZIP _____

E-MAIL _____ CELL PHONE (____) _____ PARENT CELL PHONE (____) _____

MOTHER'S NAME _____ SOCIAL SECURITY # _____

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

FATHER'S NAME _____ SOCIAL SECURITY # _____

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

NAME ALL YOUR DENTAL INSURANCE CO. _____

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

PREVIOUS DENTIST _____ WHO REFERRED YOU? _____

IN CASE OF EMERGENCY, WHO SHOULD BE CONTACTED (other than parent)? _____

NAMES AND AGES OF OTHER CHILDREN IN YOUR FAMILY _____

DENTAL HISTORY

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

YES NO 1. Have you been having any dental problems?

YES NO 2. Are you worried about going to the dentist?

YES NO 3. Do your gums bleed?

YES NO 4. Are you troubled by bad breath?

YES NO 5. Do you have sensitive teeth?

YES NO 6. Do your jaws pop, lock, or hurt when you open your mouth?

YES NO 7. Have you ever had sinus trouble?

YES NO 8. Are you unhappy with the way your teeth look?

YES NO 9. Is anything in your mouth uncomfortable?

YES NO 10. Have you ever had any of the following?

_____ Injuries to your jaws, face, or teeth?

_____ Teeth pulled?

_____ Braces or retainers?

_____ Surgery on your mouth or face?

HEALTH HISTORY

Circle YES or NO

- YES NO 1. Are you in good health?
- YES NO 2. Have you been examined by a physician within the last year?
- YES NO 3. Are you under the care of a physician for a problem now?
- YES NO 4. Have you ever been hospitalized overnight?
- YES NO 5. Have you taken any medication in the last month?
- YES NO 6. Have there been any changes in your health this year?
- YES NO 7. Have you ever been seriously ill?
- YES NO 8. Have you ever been treated for a growth or tumor?
- YES NO 9. Do you often feel exhausted or fatigued?
- YES NO 10. Do you have any painful or swollen joints?
- YES NO 11. Do you bleed a long time when you are cut?
- YES NO 12. Does anyone in your family have diabetes?
- YES NO 13. Do you have hives or skin rashes?
- YES NO 14. Have you had heart trouble?
- YES NO 15. Have you ever had an unusual reaction to a dental anesthetic, penicillin, aspirin, codeine, or other medications?
- YES NO 16. Do you have any allergies?
- YES NO 17. Is there any chance that you are pregnant?
- YES NO 18. Do you smoke or chew?
- YES NO 19. Have you ever had any of the following?
- | | |
|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chicken pox |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Murmur |
- YES NO 20. Do you have any disease, condition, or problem not listed above that I should know about?

Signature _____ Date _____

I authorize routine dental care and diagnostic records for my child. I also agree to the use of anesthetic or premedication considered necessary or advisable by the dentist for the comfort or well-being of the child.

Signature of parent _____ Date _____