

Date: _____ Update: _____

PERSONAL

Child's Full Name _____ Age _____ Birth date _____

Nickname (if any) _____ Sex _____ Place of Birth _____

What is your child most interested in? _____

Brothers, names and ages _____ Sisters _____

Is your child adopted? Y N Does your child know? Y N

Child's pediatrician or physician _____ Telephone # _____

Who may we thank for referring you? _____ Child attends what school? _____

MEDICAL

Has your child had any of the following medical problems? *Check Yes (Y) or No (N) – discuss below if necessary*

Allergies to drugs or foods	Y	N	Ear Infections	Y	N	HIV+/AIDS	Y	N
Asthma or lung problems	Y	N	Handicaps or disabilities	Y	N	Operations or Hospital/ER stays	Y	N
Blood transfusions	Y	N	Heart defect (congenital)	Y	N	Learning disabilities	Y	N
Cancer	Y	N	Heart murmur	Y	N	Rheumatic Fever	Y	N
Convulsions or epilepsy	Y	N	Hemophilia or abnormal bleeding	Y	N	Trauma to mouth or face	Y	N
Developmental delay	Y	N	Hepatitis	Y	N	Tuberculosis (TB)	Y	N
Diabetes	Y	N	High fevers	Y	N			

Other medical problems: _____

Please discuss problems further, if necessary: _____

Has your child had any unfavorable reactions to medications or anesthetics (including the operating room)? Y N

Is your child currently taking any medications? Y N What kind? _____

Does your child have any breathing problems? Y N Breathes primarily through nose or mouth? _____

Does your child snore? Y N Does your child have frequent sore throats? Y N

HABITS

Does your child have or had any of the following habits?

Thumb or finger sucking	Y	N	Pacifier use	Y	N	Nail biting	Y	N
Lip sucking or biting	Y	N	Biting hard objects	Y	N	Tooth grinding	Y	N
Did your child use a bottle?	Y	N	If yes, when did he/she stop?	_____				
Does your child currently use a bottle?	Y	N	If yes, how often during the day?	_____				
Is the bottle used at night?	Y	N	What is your child drinking?	_____				
Does your child currently nurse?	Y	N	Does your child nurse at night time?	Y	N			

FAMILY DENTAL HISTORY

Has Mother/ Father had a lot of decay? _____ Has Mother/ Father had orthodontic care? _____

Does Mother/Father have gum disease? _____ Does Mother/ Father have TMJ problems? _____

CHILD'S DENTAL HISTORY

Has your child seen a dentist before? Y N

If yes, the approximate month and year of last visit: _____ Where? _____

Has your child had any unfavorable experiences in a dental or medical office? Y N _____

Does your child currently have any dental problems (pain, infection, or orthodontic problems, etc.)? Y N

If yes, please explain: _____

How often does your child brush his/her teeth per day? _____ Do you help brush? Y N

How often does your child floss? _____ Do you help floss? Y N

How do you think your child will act today towards the dentist? _____

Purpose of today's dental visit _____

Examining Doctor's Initials _____ Date _____

PARENT INFORMATION

FATHER

Name _____

Home Address _____

Home Phone _____

Cell Phone _____

Employer's Name _____

Occupation _____

Employer's Phone _____

Employer's Address _____

DOB _____ Driver's License # _____

SS# _____ - _____ - _____

E-mail: _____

Name of Parent/Guardian that child lives with _____

Name of Parent/Guardian financially responsible _____

Best number to call to remind you of your child's appointment _____

MOTHER

Name _____

Home Address _____

Home Phone _____

Cell Phone _____

Employer's Name _____

Occupation _____

Employer's Phone _____

Employer's Address _____

DOB _____ Driver's License # _____

SS# _____ - _____ - _____

E-mail: _____

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____ Phone: _____

Name of nearest relative not living with child: _____ Phone: _____

DENTAL INSURANCE:

PRIMARY

Responsible Party _____

Carrier Name _____

Carrier Address _____

Carrier Phone _____

Group # _____

SECONDARY

Responsible Party _____

Carrier Name _____

Carrier Address _____

Carrier Phone _____

Group # _____

I (the parent) understand that the information I provide on this health and information form is essential to determine my child's dental needs and the provision of dental treatment; I understand that if any changes occur in my child's health, I am to report it to the doctor or his staff as soon as possible. I have read and understand each question, I have answered all of them truthfully and to the best of my ability; and I have discussed my child's health history with the doctor.

Parent/Guardian Signature

Dentist Signature

I authorize the use of radiographs, study models, photographs, and video recordings of my child's treatment for presentations or publications of the doctor.

Parent/Guardian Signature