WELCOME! PLEASE TELL US ABOUT YOUR CHILD....

CHILD'S NAME first______________________________middle______________________last__________________________ GENDER M F

NICKNAME/PREFERS TO BE CALLED ____ BIRTHDATE _____/_____/__________

ADDRESS street____city________________________________state_______zip________

PHONE ( ) ____________________ ALTERNATE1( ) ____________________ ALTERNATE2( ) ______________

FAMILY'S PRIMARY EMAIL ADDRESS ____@__________________

FUTURE APPOINTMENTS MAY BE CONFIRMED VIA E-MAIL. PLEASE INFORM THE STAFF IF YOU DO NOT WISH TO RECEIVE THESE E-MAILS.

WHOM MAY WE THANK FOR YOUR REFERRAL? *INTERNET SEARCH _____ *INSURANCE _____ *YELLOW PAGES_____

*ADVERTISEMENT ___________________________________ *RELATIVE/FRIEND __________________________________

*PEDIATRICIAN________________________________ *DENTIST______________________ *OTHER___________________

PARENT/GUARDIAN INFORMATION

PARENT NAME (MOM/DAD)_______________________ PARENT NAME (MOM/DAD)________________________

DATE OF BIRTH __________________________________ DATE OF BIRTH ____________________________________

SSN _____________---___________---________________ SSN _____________---___________---
____

OCCUPATION ___________________________________ OCCUPATION____________________________________

ADDRESS (IF DIFFERENT FROM ABOVE) ____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE PLAN NAME ____________________________ INSURANCE PHONE # ______________
SUBSCRIBER'S NAME ____ RELATIONSHIP TO PATIENT _________________
SUBSCRIBER'S SSN OR MEMBER/POLICY ID # __________________________ MEMBER DOB ______________________
GROUP # ______________________________ SUBSCRIBER'S EMPLOYER ____

PRIMARY DENTAL INSURANCE PLAN NAME ____________________________ INSURANCE PHONE # ______________
SUBSCRIBER'S NAME ____ RELATIONSHIP TO PATIENT _________________
SUBSCRIBER'S SSN OR MEMBER/POLICY ID # __________________________ MEMBER DOB ______________________
GROUP # ______________________________ SUBSCRIBER'S EMPLOYER ____

DENTAL HISTORY

IS THIS YOUR CHILD'S FIRST VISIT TO A DENTIST? Y / N IF NO, FORMER DENTIST ___________________________

DATE OF LAST DENTAL VISIT ___________________________ REASON? ____

HOW MANY TIMES A DAY IS YOUR CHILD BRUSHING? zero 1x 2x 3x+ DOES HE/SHE FLOSS? Y / N

TAKE FLUORIDE IN ANY OF THESE FORMS: TABLETS/DROPS TOOTHPASTE RINSE/GEL BOTTLED H2O OTHER

HAVE ANY CURRENT COMPLAINT OF DENTAL PAIN? Y/N IF YES, EXPLAIN: ____________________________________

DOES YOUR CHILD HAVE A HISTORY OF:

___ THUMB/FINGER SUCKING ___ PACIFIER ___ BOTTLE FEEDING ___ BREASTFEEDING ___ SIPPY CUP

___ SPEECH ISSUES ___ BLEEDING/SORE GUMS ___ MOUTH BREATHING ___ BAD BREATH

___ GRINDING/CLENCHING ____ ABSCESS/INFECTION ____ NAIL BITING ____OTHER _________________________

MEDICAL HISTORY

PEDIATRICIAN ____ PHONE_________________________________

ADDRESS/TOWN ____ DATE OF LAST PHYSICAL ________________

PLEASE LIST MEDICATIONS YOUR CHILD IS CURRENTLY TAKING:

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY Y / N IF YES, PLEASE EXPLAIN:

DOES YOUR CHILD HAVE ANY ALLERGIES TO ___PENICILLIN/AMOXICILLIN ___SULFA ___ LATEX ___ OTHER
(PLEASE SPECIFYALL KNOWN ALLERGIES INCLUDING FOODS AND ENVIRONMENTAL ALLERGENS):

HAS YOUR CHILD HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY:

_ AIDS/HIV
_ ADHD/ADD
_ ANEMIA
_ ASTHMA
_ AUTISM/PDD/SPECTRUM
_ BIRTH DEFECT
_ BLEEDING DISORDER
_ BLOOD TRANSFUSION
_ BONE DISORDER
_ BRONCHITIS
_ CANCER

_ CEREBRAL PALSY
_ CONVULSIONS/EPILEPSY
_ DIABETES
_ EAR INFECTIONS (CHRONIC)
_ GENETIC DISORDER
_ HEAD INURY
_ HEARING DISABILITY
_ HEART MURMUR
_ HEART PROBLEMS
_ HEPATITIS
_ HIGH BLOOD PRESSURE

_ JAUNDICE (SEVERE)
_ KIDNEY DISEASE
_ LEARNING DISABILITY
_ LIVER DISEASE
_ MEASLES
_ MONONUCLEOSIS
_ MUMPS
_ PSYCHIATRIC CARE
_ RADIATION THERAPY
_ RESPIRATORY ISSUES
_ RHEUMATIC FEVER

_ SEIZURES
_ SINUS PROBLEMS
_ SPEECH DELAY
_ STOMACH/GI PROBLEMS
_ TUBERCULOSIS
_ TUMOR
_ VISION PROBLEMS
_ OTHER (EXPLAIN BELOW)

OTHER ____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS AND INFORMATION ARE TRUE AND CORRECT. IF THERE ARE ANY CHANGES IN MY CHILD'S INFORMATION AND/OR HEALTH STATUS, I WILL INFORM THE DOCTOR AS SOON AS REASONABLY POSSIBLE AND WITHOUT FAIL. I UNDERSTAND THAT THIS INFORMATION WILL REMAIN CONFIDENTIAL

SIGNATURE OF PARENT/GUARDIAN ____DATE______________

SIGNATURE OF DOCTOR ____DATE ______________