CHILD PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Sex _____
First Middle Last

Home Address _____ Telephone # ( ) _____
Street City State Zip

Mailing Address (if different from above) _____
Street City State Zip

With whom does the child reside? _____ Father _____ Mother _____ Legal Guardian Other (list relationship) _____

Name, Address and Telephone # of Legal Guardian: _____

_____

Whom may we thank for referring you to our office? _____
Name Address Telephone #

In case of an emergency, please list a contact person. _____
Name Relationship Telephone #

Child's Social Security #: _____

PARENT/GUARDIAN INFORMATION

Father's Name _____	Mother's Name _____
Address (if different from patient) _____	Address (if different from patient) _____
_____	_____
Telephone # _____ Cell # _____	Telephone # _____ Cell # _____
Birthdate _____ Social Security # _____	Birthdate _____ Social Security # _____
Employer _____	Employer _____
Position _____	Position _____
Work Telephone # _____	Work Telephone # _____

Parents' Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

FATHER'S DENTAL INSURANCE INFORMATION	MOTHER'S DENTAL INSURANCE INFORMATION
Insurance Co. _____	Insurance Co. _____
Address _____	Address _____
_____	_____
Employer _____	Employer _____
Phone # _____	Phone # _____
Policy # _____	Policy # _____
Group # _____	Group # _____
Employee S.S. # _____	Employee S.S. # _____

May we request release of your child's medical records for our reference? ❑ Yes ❑ No
I have completed the requested information on this form to the best of my knowledge.
I will allow pictures to be taken of my child for the sole purpose of dental treatment and office management.

_____ _____ _____
Date Signature Relationship to child

MEDICAL HISTORY

Child's Physician _____ Address _____ Phone ( ) _____

_____

Date of last physical examination _____ Results _____

Pharmacy Name _____ Location _____ Phone ( ) _____

Is child under the care of a physician? ❑ Yes ❑ No
If yes, please explain: _____

Is the child receiving any medications or drugs? ❑ Yes ❑ No
If yes, please list and explain reason for taking: _____

Has your child ever been hospitalized? ❑ Yes ❑ No
If yes, please explain: _____

Has your child ever had surgery? ❑ Yes ❑ No
If yes, please explain: _____

Is your child allergic to ❑ Penicillin ❑ Codeine ❑ Latex, Metals, Plastics ❑ Local Anesthetics (Novocaine)
❑ Other – which ones? _____

Are there any emotional problems? Explain: _____

Please check the following to indicate "YES" regarding this patient:

❑ Apthous ulcers frequent (canker sores)
❑Breath odor
❑ Herpetic lesions frequent (cold sores)
❑ Earaches
❑ Headaches
❑ Jaws making clicking, grinding or popping noise
❑ Neck pain
❑ Orthodontic concerns (crooked teeth or bite)
❑ Snore at night
❑ Frequent consumption of carbonated beverages
❑ Speech impaired/unusual speech habits
_____
❑ Strong gag reflex
❑ Frequent vomiting
❑ Smoking
❑ Chewing tobacco
❑ Self-induced purging (bulimia)
❑ Finger-sucking: ❑ frequent ❑ occasionally
❑ Thumb-sucking: ❑ frequent ❑ occasionally
❑ Pacifier: ❑ frequent ❑ occasionally
❑ Nursing or bottle habit
❑ Teeth grinding
❑ Teeth clenching
❑ Mouth bleeding
❑ Nail biting
❑ Lip or sucking

Check if child has any history or difficulty with any of the following:

❑ ADD (Attention Deficit Disorder)
❑ ADHD (Attention Deficit Hyperactive Disorder)
❑ AIDS (HIV)
❑ Anemia
❑ Arthritis
❑ Anorexia
❑ Asthma _____ frequency of attacks ❑ exercise-induced
❑ Autism
❑ Bladder
❑ Bleeding problems
❑ Blood pressure concerns
❑ Blood transfusion – explain _____
❑ Bruises easily
❑ Chicken pox
❑ Convulsions/Epilepsy/Seizures
❑ Depression
❑ Diabetes
❑ Fainting spells
❑ Hearing impaired
❑ Heart murmur
❑ Heart condition – explain _____
_____
(NOTE: Your child may require antibiotic prior to dental treatment.)
❑ Hepatitis type: A B C Other
❑ Hives or skin rash
❑ Liver disease
❑ Malignancies
❑ Mastoid
❑ Measles
❑ Mononucleosis
❑ Mumps
❑ Nervousness
❑ Persistent cough or coughing up blood
❑ Rheumatic Fever
❑ Thyroid
❑ Tuberculosis
❑ Venereal disease
❑ Surgery or radiation treatment for tumor, growth or condition of the head or neck