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Welcome! Whom may we thank for referring you? _____

Do we see other family members? _____

Patient's name: First _____Last _____Mid/nick_____

Date of Birth _____ male _____female _____ age _____

Address _____City _____State _____Zip _____

Home phone _____ Cell phone _____ email_____

Family Dentist_____
Name address phone

Who is accompanying the child today? _____

Please read very carefully, accuracy is most important!

Medical history

Child's physician _____
Name address phone

General state of health _____Excellent _____Fair _____Poor
Date of last physical examination? _____
Has your child been under a physicians care recently? ___Yes ___No
Reason: _____

Has your child been hospitalized recently? ___Yes ___No
Reason: _____

Is your child now taking (or during the last 6 months) any medications?
If yes, medicine: _____Reason _____ ___Yes ___No

Has your child ever had a serious illness or operation? ___Yes ___No
If yes, please explain: _____

Does your child have any allergies? ___Yes ___No
If yes, to what? _____

Please check if your child has ever had any of the following:

___Artificial Heart Valve	___Blood Disease	___Lung trouble	___Hearing/Speech Issues
___Blood Disease	___Hemophilia	___Shortness of Breath	___Diabetes
___Circulatory Problems	___Anemia	___Asthma	___Kidney Disease
___Heart Murmur	___HIV+/AIDS	___Tuberculosis	___ Liver Cond/Hepatitis
___High Blood Pressure	___Stroke	___Radiation treatment	___Thyroid Condition
___Mitral Valve Prolapse	___Ulcer	___Cerebral Palsy	___Tobacco Habit
___Rheumatic Fever	___Tonsillitis	___Blood Transfusions	___Chemical Dependency
___Heart Disease	___Cancer	___Psychiatric Care	___ Handicaps/Disabilities
Describe _____	___Chemotherapy	___Bleeding problems	___Developmental Issues
___Cortisone Treatment	___ ADD/ADHD	___Autism	___Epilepsy/convulsions

Other important health issues _____

Has your child's physical development been normal? ____Yes ____No
If no, please explain: _____
_____

Does your child have any emotional, neurological or learning issues? ____ Yes ____No
If yes, please explain: _____
_____

Dental History

Is this your child's first dental visit? _____Yes _____No
Date of child's last dental visit ___
Dentist's Name _____Phone/Address_____
Reason for last dental visit _____
Were x-rays taken? _____Yes _____No Do you have copies of them? ____Yes ____No
Was your child's last dental experience pleasant? _____Yes _____No
If not, please explain: _____

Does your child have any history of the following? Please check:

_____ teeth extracted	_____ orthodontic treatment	____ tongue thrusting
_____ nerve treatment	_____ local anesthetic (Novacaine)	____ bottle nursing
_____ injury to teeth or face	_____ finger/thumb sucking	

Any concerns about your child's teeth? _____
_____

How many children in your family? _____ Ages _____

Patients favorite toys, hobbies, pets, TV shows, etc. _____
_____

Parental Information

Father's name _____	**Mother's name** _____
Occupation _____	**Occupation** _____
Social Sec # _____	**Social Sec #** _____
Birth Date _____	**Birth Date** _____
Employer: _____	**Employer:** _____
Work address: _____	**Work address:** _____
_____	_____
Business Phone_____	**Business Phone** _____
Dental Ins. Co _____	**Dental Ins. Co** _____
Group/policy # _____	**Group/policy #** _____
Subscriber # _____	**Subscriber #** _____
Ins. address _____	**Ins. address** _____
Ins. phone # _____	**Ins. phone #** _____
Cell phone _____	**Cell phone** _____

I certify that I read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to the child's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.**

X_____ _____

Signature of patient (or parent if a minor) **TODAY'S DATE**