CONFIDENTIAL

CHILD'S NAME: ____________________

ADDRESS ____________________

CITY ____________ STATE ________ ZIP ________

IF PT IS A STUDENT, NAME OF SCHOOL____________________

WHOM MAY WE THANK FOR REFERRING YOU? ____________________

BIRTHDATE ____________________

HOME PHONE ____________________

CELL PHONE ____________________

OTHER ____________________

EMAIL ____________________

RESPONSIBLE PARTY

FATHER(S) NAME ____________________

DATE OF BIRTH: ____________ SSN# ____________

EMPLOYER: ____________ OCCUPATION ____________

HOME PHONE ____________________

WORK PHONE ____________________

CELL PHONE ____________________

MOTHER(S) NAME ____________________

DATE OF BIRTH: ____________ SSN# ____________

EMPLOYER: ____________ OCCUPATION____________

HOME PHONE ____________________

WORK PHONE ____________________

CELL PHONE ____________________

CIRCLE APPROPRIATE SELECTION:
SINGLE MARRIED DIVORCED WIDOWED SEPERATED

PATIENT MEDICAL HISTORY

PHYSICIAN NAME ____________________

PHYSICIAN PHONE ____________________

- IS YOUR CHILD UNDER THE CARE OF A PHYSICIAN YES NO
- HAS YOUR CHILD BEEN HOSPITALIZED IN THE LAST FIVE YEARS YES NO
- IS YOUR CHILD TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION. YES NO
- DOES YOUR CHILD HAVE ANY ALLERGIES YES NO
  ____
  ____
- HAS YOUR CHILD EVER HAD A REACTION TO ANESTHETIC? YES NO

DATE OF LAST EXAM ____________________

EXPLAIN ANY ANSWERS MARKED YES
____
____
____
____
____
____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOUR CHILD:

	YES	NO		YES	NO
ASTHMA	___	___	HEART MURMUR	___	___
ANEMIA	___	___	HEART DISORDER	___	___
BLEEDING DISORDER	___	___	HIV/AIDS	___	___
DIABETES	___	___	HEPATITIS	___	___
EPILEPSY	___	___	KIDNEY DISORDER	___	___
EYE DISORDER	___	___	LIVER DISORDER	___	___
HEARING DISORDER	___	___	SURGERIES	___	___
MALIGNANCY/NEOPLASM	___	___			

LEARNING DISABILITY OR ADD/ADHD/AUTISM: ____________________

EXPLAIN ANY ANSWERS MARKED YES

____

____

____

____

PATIENT DENTAL HISTORY

	YES	NO
1. PAIN IN ANY OF YOUR CHILD'S TEETH?	_____	_____
2. ANY SORES OR LUMPS IN THE MOUTH?	_____	_____
3. EVER SUFFERED TRAUMA TO THE FACE?	_____	_____
4. PROBLEMS WITH PREVIOUS DENTAL WORK?	_____	_____

5. DO YOU BRUSH YOUR CHILD'S TEETH?
6. IF SO, HOW OFTEN? ______________________________________
7. HOW OFTEN DOES YOUR CHILD FLOSS? ______________________

REASONS FOR TODAY'S VISIT:

____

____

HAS YOUR CHILD EVER HAD AN UNPLEASANT EXPERIENCE IN A DENTAL OFFICE

____

____

____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

____

LEGAL GUARDIAN'S SIGNATURE DATE

____

PRINT NAME

____

DENTIST SIGNATURE

____

DATE

____

WITNESS SIGNATURE

____

DATE