About Your Child

Date: _____/_____/_____

Last Name:	First:		M.I.
Nickame:			Gender: ☐Male ☐Female
Birthdate: / /	Age:	SS#	
Special interests, sports or hobbies:			
Home Address:		City:	
State:	Zip:	Home #: ( ) -	
Referred By:			

ABOUT YOU

Last Name:	First:	M.I.	☐MR. ☐MRS . ☐MS. ☐DR.
Birthdate: / /	SS#		
Relationship to child:			
Home Address *(If different than Child's)*:		City:	
State:	Zip:	Home #: ( ) -	Cell #: ( ) -
Occupation:			
Employer:		Work # ( ) -	Ext.

INSURANCE INFORMATION

PRIMARY COVERAGE	Dental Coverage: ☐YES ☐NO		
Insurance Company:		Ph #: ( ) -	
Insurance Address:	City:	State	Zip
Group # (Plan, Local or Policy #):	Insured's ID #		
Insured's Employer:	Insured's Name:		
Relation:	Insured's Birthday: _____/_____/_____		

SECONDARY COVERAGE

SECONDARY COVERAGE	Dental Coverage: ☐YES ☐NO		
Insurance Company:		Ph #: ( ) -	
Insurance Address:	City:	State	Zip
Group # (Plan, Local or Policy #):	Insured's ID #		
Insured's Employer:	Insured's Name:		
Relation:	Insured's Birthday: _____/_____/_____		
In case of an emergency, whom should we contact?			
Name:	Relationship:		
Phone #: ( ) -	Phone 2 #: ( ) -		

DENTAL / MEDICAL HISTORY (Continued on page 2)

Has your child been to the dentist before? ☐YES ☐NO	If yes, the approximate date of the last visit:
Are there any dental problems that you are aware of at present? ☐YES ☐NO	
If yes, please explain:	
Does your child brush his / her teeth daily? ☐YES ☐NO	Please rate your child's oral health: ☐Good ☐Fair ☐Poor

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DENTAL / MEDICAL HISTORY (Continued)

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Does your child have a personal physician? ☐YES ☐NO	Date of last visit:		
Physician's Name:			Ph #: ( ) -
Is your child under a physician's care now?	☐YES ☐NO	If yes, please explain:	
Is your child taking any medications, pills or drugs?	☐YES ☐NO	If yes, please explain:	
Has your child ever been hospitalized or had a major operation?	☐YES ☐NO	If yes, please explain:	
Has your child ever had a serious head or neck injury?	☐YES ☐NO	If yes, please explain:	
Has your child taken Fosamax, or any other bisphosphonate	☐YES ☐NO	If yes, please explain:	
Has your child taken Phen-Fen or Redux?	☐YES ☐NO	If yes, please explain:	
Is your child on a special diet?	☐YES ☐NO	If yes, please explain:	
Does your child smoke or use tobacco?	☐YES ☐NO	If yes, please explain:	
Does your child use controlled substances?	☐YES ☐NO	If yes, please explain:	
Is your child pregnant or trying to get pregnant?	☐YES ☐NO	If yes, please explain:	
Does your child taking oral contraceptives?	☐YES ☐NO	If yes, please explain:	
Is your child nursing	☐YES ☐NO	If yes, please explain:	

Is your child allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Metal Latex Acrylic

Other? If yes, please explain:

DOES YOUR CHILD HAVE, OR HAS YOUR CHILD HAD, ANY OF THE FOLLOWING?:

AIDS HIV Positive	☐YES	☐NO	Excessive Thirst	☐YES	☐NO	Lung Disease	☐YES	☐NO
Alzheimers	☐YES	☐NO	Fainting Spells / Dizziness	☐YES	☐NO	Mitral Valve Prolapse	☐YES	☐NO
Anaphylaxis	☐YES	☐NO	Frequent Cough	☐YES	☐NO	Pain in the Jaw Joints	☐YES	☐NO
Anemia	☐YES	☐NO	Frequent Diarrhea	☐YES	☐NO	Parathyroid Disease	☐YES	☐NO
Angina	☐YES	☐NO	Frequent Headaches	☐YES	☐NO	Psychiatric Care	☐YES	☐NO
Arthritis/Gout	☐YES	☐NO	Genital Herpes	☐YES	☐NO	Radiation Treatments	☐YES	☐NO
Artificial Heart Valve	☐YES	☐NO	Glaucoma	☐YES	☐NO	Recent Weight Loss	☐YES	☐NO
Artificial Joint	☐YES	☐NO	Hay Fever	☐YES	☐NO	Renal Dialysis	☐YES	☐NO
Asthma	☐YES	☐NO	Heart Attack/Failure	☐YES	☐NO	Rheumatic Fever	☐YES	☐NO
Blood Disease	☐YES	☐NO	Heart Murmur	☐YES	☐NO	Rheumatism	☐YES	☐NO
Blood Tranfusion	☐YES	☐NO	Heart Pace Maker	☐YES	☐NO	Scarlet Fever	☐YES	☐NO
Breathing Problem	☐YES	☐NO	Heart Trouble/Disease	☐YES	☐NO	Shingles	☐YES	☐NO
Bruise Easily	☐YES	☐NO	Hemophilia	☐YES	☐NO	Sickle Cell Disease	☐YES	☐NO
Cancer	☐YES	☐NO	Hepatitis A	☐YES	☐NO	Sinus Trouble	☐YES	☐NO
Chemotherapy	☐YES	☐NO	Hepatitis B or C	☐YES	☐NO	Spinal Bifida	☐YES	☐NO
Chest Pains	☐YES	☐NO	Herpes	☐YES	☐NO	Stomach/Intestinal Disease	☐YES	☐NO
Cold Sores/Fever Blisters	☐YES	☐NO	High Blood Pressure	☐YES	☐NO	Stroke	☐YES	☐NO
Congenital Heart Disorder	☐YES	☐NO	Hives or Rash	☐YES	☐NO	Swelling of Limbs	☐YES	☐NO
Convulsion	☐YES	☐NO	Hypoglycemia	☐YES	☐NO	Thyroid Disease	☐YES	☐NO
Cortisone Medication	☐YES	☐NO	Irregular Heartbeat	☐YES	☐NO	Tonsilitis	☐YES	☐NO
Diabetes	☐YES	☐NO	Kidney Problems	☐YES	☐NO	Tuberculosis	☐YES	☐NO
Drug Addiction	☐YES	☐NO	Leukemia	☐YES	☐NO	Tumors or Growths	☐YES	☐NO
Easily Winded	☐YES	☐NO	Liver Disease	☐YES	☐NO	Ulcers	☐YES	☐NO
Emphysema	☐YES	☐NO	Low Blood Pressure	☐YES	☐NO	Venereal Disease	☐YES	☐NO
Epilepsy or Seizures	☐YES	☐NO	Excessive Bleeding	☐YES	☐NO	Yellow Jaundice	☐YES	☐NO

Have your child ever had any serious illness not listed above? ☐YES ☐NO If yes, please explain:_____

Comments_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes to medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____DATE_____/_____/_____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also repsonsible for paying any co-payment and deductible that my insurance does not cover.

Signature_____ Date_____

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: (Parent or Guardian if minor)X_____ Date_____