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Patient Information

Child's Name _____

Preferred Name _____ ❑ M ❑ F Child's Birthdate _____ / _____ / _____

PatientAddress:_____

City:_____ State:_____ Zip:_____

Email Address:_____

(We confirm appointments by text messages and e-mail, in addition to postcards)

Mother's Name

_____

Mother's Address ❑ Check if same as child's

_____

City:_____State:_____Zip:_____

Birthdate ____ / ____ / ____ Employer _____

Cell # (_____) _____-_____

Home # (_____) _____-_____

Father's Name

_____

Father's Address ❑ Check if same as child's

_____

City:_____State:_____Zip:_____

Birthdate ____ / ____ / ____ Employer _____

Cell # (_____) _____-_____

Home # (_____) _____-_____

Account Information

Person ultimately responsible for this account:

Name _____Relation to Child _____

Billing Address_____

Cell # (_____) _____-_____ Home # (_____) _____-_____

Policy Holder Information

Does the patient currently have Dental Insurance?

YES NO

Employer:_____

Card Holder's Name:_____

SSN of Card Holder:_____-_____-_____

Card Holder's Date of Birth:_____

Insurance Company:_____

Group/Contract Number:_____

Does the patient currently have Secondary Dental Coverage?

YES NO

Employer:_____

Card Holder's Name:_____

SSN of Card Holder:_____-_____-_____

Card Holder's Date of Birth:_____

Insurance Company:_____

Group/Contract Number:_____

Parent/Guardian Signature:_____ Date: _____

Medical History

Child's Name _____

Preferred Name _____ ❑ M ❑ F Child's Birthdate _____ / _____ / _____

Does the patient have any of the following?

ADD/ADHD	YES	NO	Cleft Lip	YES	NO	Kidney Disorder	YES	NO
Aids/HIV Positive	YES	NO	Cystic Fibrosis	YES	NO	Liver Disorder	YES	NO
Anemia	YES	NO	Diabetes	YES	NO	Lung Disorder	YES	NO
Asthma	YES	NO	Down's Syndrome	YES	NO	Mental Disorder	YES	NO
Aspergers Syndrome	YES	NO	Endocrine	YES	NO	Muscle Disorder	YES	NO
Autism	YES	NO	Gastric Reflux	YES	NO	Rheumatic Fever	YES	NO
Bleeding Disorder	YES	NO	Heart Defects	YES	NO	Seizures/Epilepsy	YES	NO
Bone Disorder	YES	NO	Heart Murmur	YES	NO	Sickle Cell Anemia	YES	NO
Cancer/Tumors	YES	NO	Hemophilia	YES	NO	Sleep Apnea	YES	NO
Cerebral Palsy	YES	NO	Hepatitis	YES	NO	Tuberculosis	YES	NO

Does the child have any allergies? YES NO

If YES, Name:_____

_____

Latex Allergies? YES NO

Milk Allergies? YES NO

Amoxicillin Allergies? YES NO

If YES on any, please elaborate:

_____

_____

Is the child currently being treated by a physician for any medical problems? YES NO

_____

Is the child taking any medications? YES NO

If YES, Name:_____ Dose:_____ Reason:_____

Name:_____ Dose:_____ Reason:_____

Name:_____ Dose:_____ Reason:_____

Child's Dental Information

Has your child ever been to the dentist before? YES NO

If YES:Name of Office and Location: _____

Date of Last Cleaning: _____

Is your child currently seeing or have they previously seen an orthodontist? If Yes, When and Who?

_____

How did you hear about us? Please circle one: Newspaper / Phone Book / Internet / We Visited your child's school or day care / Friend / Referring Doctor _____Other_____

Is your child in pain? ❑ N ❑ Y For how long? _____

Has the child been hospitalized, had any surgeries or been to the ER for any tooth/mouth related problems? YES NO

If YES, please elaborate: _____

How often does your child Brush? _____ How often does your child Floss? _____

Does child do any of the following? ❑ Thumb Sucking ❑ Tongue Thrusting ❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting ❑ Tooth Grinding/Clenching ❑ Nail Biting ❑ Nursing

Parent/Guardian Signature:_____ Date: _____