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Patient Information

Child's Name _____

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

Patient Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

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

Mother's Name _____

Father's Name _____

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

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

City: _____ State: _____ Zip: _____

City: _____ State: _____ Zip: _____

Birthdate ____ / ____ / ____ Employer _____

Birthdate ____ / ____ / ____ Employer _____

Cell # (____) _____ - _____

Cell # (____) _____ - _____

Home # (____) _____ - _____

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**?

Does the patient currently have **Secondary Dental Coverage**?

YES NO

YES NO

Employer: _____

Employer: _____

Card Holder's Name: _____

Card Holder's Name: _____

SSN of Card Holder: _____ - _____ - _____

SSN of Card Holder: _____ - _____ - _____

Card Holder's Date of Birth: _____

Card Holder's Date of Birth: _____

Insurance Company: _____

Insurance Company: _____

Group/Contract Number: _____

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: _____