PATIENT INFORMATION

Date _____

M ☐ F ☐

Home Phone _____

Name_____Nickname_____ Birthdate_____

Last First Initial

Address _____ Social Security # _____

_____

In case of Emergency, who should we contact

Father's name _____ Phone Number _____

Mother's name _____ Phone Number _____

Child lives with_____ Phone Number _____

Physician's name_____ Phone Number _____

Previous dentist_____ Phone Number _____

Last visit date_____ Reason _____

Referred by: Name_____ Family ☐ Friends ☐ Ins. website ☐

Other website ☐ Sign ☐

Primary Dental Insurance

Insurance Company Name_____ Phone Number _____

Insurance Company Address_____ Policy Number _____

Insured's Name_____Birthday_____ SS# _____

Relationship to Patient _____

Insured's Employer _____

Secondary Dental Insurance

Insurance Company Name_____ Phone Number _____

Insurance Company Address_____ Policy Number _____

Insured's Name_____Birthday_____ SS# _____

Relationship to Patient _____

Insured's Employer _____

Person Responsible for the Account

Name_____Relation_____ SS# _____

Billing Address _____ Phone _____

_____

PATIENT INFORMATION

Has the child ever had any of the following medical problems?

Y	N	Heart Murmur	Y	N	Congenital Heart Defect
Y	N	Cancer	Y	N	Convulsions/Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheumatic Fever	Y	N	Hearing Impairment
Y	N	HIV+ /AIDS	Y	N	Any Operations
Y	N	Hemophilia	Y	N	Any stays in a hospital
Y	N	Asthma	Y	N	Kidney/Liver Problems
Y	N	Hepatitis	Y	N	Handicaps/Disabilities
Y	N	Tuberculosis (TB)	Y	N	Allergies to any drugs

Please list: _____

Please describe the child's current physical health:

Good ☐ Fair ☐ Poor ☐

Please discuss any serious medical problems that the child has had:

_____

_____

Please list all drugs that the child is currently taking:

_____

_____

Y	N	Has the child ever had a serious/difficult problem associated with previous dental work?
Y	N	Is the child's water fluoridated?
Y	N	Is the child taking fluoridated supplements at home or school?
Y	N	Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?
Y	N	Does the child brush their teeth daily?
Y	N	Floss his/her teeth daily?
Y	N	Is the child currently under the care of a physician? Physician's name _____

Physician's phone _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child my need.

_____

Signature of Patient or Guardian Date

OFFICE USE ONLY

Date & Signature _____ Med Hx Review _____

Date & Signature _____ Med Hx Review _____

Date & Signature _____ Med Hx Review _____

Date & Signature _____ Med Hx Review _____

Date & Signature _____ Med Hx Review _____