

PATIENT INFORMATION

Child's Name (First/Middle/Last) _____
Birth Date _____ Current Gender Identity _____
Address: _____ Home#: _____ Pronoun _____
City: _____ State: _____ Zip: _____
Has any member of your family been treated in our office? ☐ No ☐ Yes
Has your child been treated by another dentist? ☐ No ☐ Yes, Dr. _____
Who may we thank for referring you to our office? _____

PARENT/GUARDIAN INFORMATION

Relationship to patient: _____	Relationship to patient: _____
Name (First/Middle/Last) _____	Name (First/Middle/Last) _____
DOB: _____ SS#: _____	DOB: _____ SS#: _____
Drivers License #: _____	Drivers License #: _____
Address: _____	Address: _____
City/State/Zip _____	City/State/Zip _____
Home#: _____	Home#: _____
Cell/Work#: _____	Cell/Work#: _____
Employer: _____	Employer: _____
Email: _____	Email: _____

INSURANCE INFORMATION

Please notify the office of any insurance changes at each visit that may affect your account. As a courtesy, we will bill your insurance company on your behalf. You are responsible for any remaining balance.

Subscriber (First/Middle/Last) _____	Subscriber (First/Middle/Last) _____
DOB: _____ ID#: _____	DOB: _____ ID#: _____
Primary Insurance Co.: _____	Secondary Insurance Co.: _____
Phone#: _____	Phone#: _____

EMERGENCY CONTACT

Person to contact in case of an emergency other than parent/guardian.

Name: _____ Phone#: _____ Alt#: _____
Address/City/State: _____

AUTHORIZATION

I hereby authorize direct payment to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I understand that any previous balances must be paid before future care will be given. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge and may be used to contact me at anytime.

SIGNATURE OF RESPONSIBLE PARTY: Relationship to patient: _____

X _____ Date: _____

Last Name: _____ First Name: _____

DENTAL AND MEDICAL HISTORY QUESTIONNAIRE (Please answer every question.)

- ☐ Yes ☐ No 1. Has the child had any unusual or unpleasant experiences in a dental or medical office?
- ☐ Yes ☐ No 2. Has the child had any injuries to the face, mouth or teeth?
- ☐ Yes ☐ No 3. Was the child breast fed? How long? _____
- ☐ Yes ☐ No 4. Does the child have any oral habits such as thumb sucking or sleeping with a bedtime bottle?
- ☐ Yes ☐ No 5. Is there a chief concern regarding the child's oral health? Explain: _____
- ☐ Yes ☐ No 6. Is the child presently in good health?
- ☐ Yes ☐ No 7. Are the child's immunizations current? Child's Physician: _____
- ☐ Yes ☐ No 8. Has the child been in a hospital or had surgery? Describe: _____
9. Please describe any current medical treatment, pending surgery, recent injury or any other information: _____
- ☐ Yes ☐ No 10. Is the child taking any medications at this time? List: _____
- ☐ Yes ☐ No 11. Does the child attend any class or school?
- ☐ Yes ☐ No 12. Does the child have any abnormal behavior? Describe: _____
- ☐ Yes ☐ No 13. Were there any problems during pregnancy, delivery or during the child's first year of life?
- ☐ Yes ☐ No 14. Has the child had any unusual reaction or allergy to medications such as penicillin, aspirin, or local anesthetics?
- ☐ Yes ☐ No 15. Does the child have a history of allergies? List: _____
- ☐ Yes ☐ No 16. Is the child pregnant?
17. Do you obtain your drinking water from ☐ A Well ☐ Bottled Water ☐ A Water Purifier ☐ City Water

MEDICAL DIAGNOSIS HISTORY

- | | | | | | |
|--|----------------------|--|---------------------|--|---------------------------|
| ☐ Yes ☐ No | ADD/ADHD | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Kidney Disease |
| ☐ Yes ☐ No | AIDS/HIV | ☐ Yes ☐ No | Ear Infections | ☐ Yes ☐ No | Learning Disability |
| ☐ Yes ☐ No | Anemia | ☐ Yes ☐ No | Epilepsy | ☐ Yes ☐ No | Liver Disease |
| ☐ Yes ☐ No | Asthma | ☐ Yes ☐ No | Unusual Bleeding | ☐ Yes ☐ No | Nutritional Problem |
| ☐ Yes ☐ No | Autism/SID | ☐ Yes ☐ No | Faintness/Dizziness | ☐ Yes ☐ No | Rheumatic Fever |
| ☐ Yes ☐ No | Behavior Problems | ☐ Yes ☐ No | Heart Murmur | ☐ Yes ☐ No | Sickle Cell Disease/Trait |
| ☐ Yes ☐ No | Birth Defects | ☐ Yes ☐ No | Heart Trouble | ☐ Yes ☐ No | Sleep Apnea |
| ☐ Yes ☐ No | Cancer or Tumors | ☐ Yes ☐ No | Hearing Problems | ☐ Yes ☐ No | Speech Problems |
| ☐ Yes ☐ No | Cerebral Palsy | ☐ Yes ☐ No | Hepatitis | ☐ Yes ☐ No | Tonsillitis |
| ☐ Yes ☐ No | Cognitively Impaired | ☐ Yes ☐ No | High Blood Pressure | ☐ Yes ☐ No | Tuberculosis |
| ☐ Yes ☐ No | Convulsions/Seizures | ☐ Yes ☐ No | High Fevers | ☐ Yes ☐ No | Vision Problems |

☐ Yes ☐ No Other _____

The medical history on this page is correct to the best of my knowledge and I will update the office of any changes.

Signature _____

Date _____