Today's Date:_____

Name:_____ Preferred name:_____ Gender: _____

Home address:_____

Home Phone:_____ Cell Phone:_____

Email: _____ Preferred appt reminder method: ( )Email ( )Phone (home /cell)

Birthdate: _____ Age: _____

Who is accompanying the child today? _____ Relation: _____
Whom may we thank for referring you? _____
Other family member seen by us: _____

Parent's Information: Marital Status:_____ Who is financially responsible for the account? _____

Mother: _____ Date of Birth:_____ Home #: _____ Cell #: _____
_
Address: _____ SSN# _____

Employer: _____ Work #: _____

Father: _____ Date of Birth:_____ Home #: _____ Cell #: _____

Address:_____ SSN# _____

Employer: _____ Work #: _____

Do you have orthodontic insurance? Y / N

Name of Policy Holder: _____ Date of Birth: _____ Relation to Patient_____

Primary Insurance Company: _____ ID # _____ Group #_____

Claims Mailing Address:_____

Secondary Company: _____ ID #: _____ Group #_____

Claims Mailing Address: _____

Dental History

Present Dentist: _____ Town/State: **_____** **Date of Last Visit: _____**
Is the child currently in pain? _____
What is the primary reason for today's visit? _____
Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? _____
Has the child experienced problems with previous dental work? _____
Is the child's water fluoridated? Y / N Is the child taking fluoridated supplements? Y/ N
Does the child brush his/her teeth daily? Y / N Floss his/her teeth daily? Y / N
Has there been any trauma to the teeth or jaws? Y/N Date and Description: _____
Have you been informed of any missing or extra permanent teeth? Y / N

Does he/she have any of the following habits?

Y / N Used Pacifier Until what age? _____ Y / N Tongue Thrust
Y / N Thumb/Finger Suck Until what age? _____ Y / N Mouth Breathing
Y / N Chewing on Objects Y / N Nail Biting Y / N Tongue/Cheek Biting
Y / N Clenching/Grinding Y / N Speech Problems Y / N Lip Sucking/Biting
Y / N Was your child breast fed?

Medical History

Child's Physician: _____

Address: _____

Phone #: _____ Date of Last Visit: _____

Child's current physical health is: Good Fair Poor Is the child currently under the care of a physician? Y / N
Please Explain: _____

Are Immunizations current? Y /N

List all drugs the child is currently taking: _____

Is your child allergic to any of the following?

Aspirin	Latex	Dental Anesthetics	Sulfa Drugs
Barbiturates	Penicillin	Codeine	Sedatives
Erythromycin	Tetracycline	Jewelry/Metal/Nickel	

Other:_____

List any drugs/material that may cause allergic reactions:
_____

Does or has the child experiences the following?

Abnormal Bleeding	Hearing Impairment	Rheumatic Fever
AIDS/HIV+	Headaches	Measles
Allergies	Handicaps/Disabilities	Mitral Valve Prolapse
Anemia	Heart Murmur	Scarlet Fever
Any Hospital Stays/Operations	Hemophilia	Seizures
Asthma	Hepatitis	Sickle Cell Disease
Blood Transfusion	High Blood Pressure	Skin Rash
Cancer	Kidney Problems	Tonsillitis
Chemotherapy	Liver Problems	Tuberculosis (TB)
Chicken Pox	Low Blood Pressure	Thyroid Problems
Convulsion	Lupus	Epilepsy
Congenital Heart Defect	Mononucleosis	
Diabetes	Persistent Cough	

Please list any serious medical condition(s) that the child has experienced:

_____

Authorization:
I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Signature of Parent / Guardian:_____

Date: _____