Welcome to our office!

We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: ___________________________ Date of birth: _______________ Sex: ______

Age:______ Height: ___________ Weight: __________

Home address: _______________________________ City: __________________State: _______ Zip: ____________

Primary Phone: __________________ Emergency Contact (Name/Phone Number): _________________

Father/Legal Guardian: _____________________________

Father's contact number___________________________

Mother/Legal Guardian: _____________________________

Mother's contact number: ___________________________

Who has legal custody? _____________________________

Are parents and child living together? __________________

Relation to Patient: _________________________________

Relation to Patient: _________________________________

Person responsible for payment of account: ______________

Comments: _______________________________________

____

Patient Insurance Information

Dental Insurance: ☐ Yes ☐ No

If yes, please answer the following questions thoroughly. If you do not have your insurance information then you will be responsible for payment of services rendered.

Insurance Company: _______________________ Member ID #: _________________

Group #: _______________

Subscriber Name: __________________________________ Subscriber's Date of Birth: ___________________________

Subscriber's employer: ______________________________

How did you hear about us/Referred to us by: ____________________________

MEDICAL HEALTH HISTORY
for Children 12 and Under

Allergies – Is your child allergic to or has he/she had a reaction to:

	Yes	No		Yes	No
Local anesthetics ______________________	☐	☐	Sulfa drugs or Iodine ____________________	☐	☐
Latex/Rubber ________________________	☐	☐	Metals ______________________________	☐	☐
Aspirin ______________________________	☐	☐	Codeine or other narcotics _______________	☐	☐
Penicillin or other Antibiotics _____________	☐	☐	Epinephrine __________________________	☐	☐
Barbiturates, sedatives or sleeping pills________	☐	☐	Other _______________________________	☐	☐

	Yes	No	
Is your child currently under the care of a physician?	☐	☐	Physician Name: Phone:
Has a physician or previous dentist recommended that your child take antibiotics prior to dental treatment?	☐	☐	Address/City/State/Zip:
Does your child have any current health problems? If yes, please indicate below where appropriate.	☐	☐	Date of last physical exam:
Has your child had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	If yes, please explain: ______________________________

Is your child taking any medications/drugs/pills/supplements? If so, please list: ______________________________

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Does your child have, or has your child ever had, any of the following?

Diabetes ________________________________	☐	☐	Oral Herpetic Lesion ______________________	☐	☐
Heart Defects ____________________________	☐	☐	HIV-positive/AIDS ________________________	☐	☐
Asthma _________________________________	☐	☐	Tuberculosis ____________________________	☐	☐
Hay fever _______________________________	☐	☐	Cerebral palsy ___________________________	☐	☐
Kidney infection __________________________	☐	☐	Cancer _________________________________	☐	☐
Liver problems ___________________________	☐	☐	Eating Disorders __________________________	☐	☐
Hepatitis/Jaundice _________________________	☐	☐	Speech impairments ______________________	☐	☐
Thyroid Problems __________________________	☐	☐	Hearing Impaired _________________________	☐	☐
Rheumatic fever ___________________________	☐	☐	Cleft Lip/Cleft Palate ______________________	☐	☐
Epilepsy/Seizures/Fainting __________________	☐	☐	Emotional or Behavior Problem (i.e. ADD/ADHD) __	☐	☐
Abnormal bleeding/Hemophilia _______________	☐	☐	Autism _________________________________	☐	☐
GI problems ______________________________	☐	☐	Other __________________________________	☐	☐

If you checked any of the above, please explain: ____

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AUTHORIZATION AND RELEASE

To the best of my knowledge, the information that I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my child's health. I understand that I am solely responsible for any errors or omissions made in the completion of this form. I understand that it is my responsibility to inform my doctor if my child has a change in health.

Parent/Guardian Signature ______________________________________ Date ____________________