PLEASE COMPLETE THE ENTIRE FORM

DATE: _____

PATIENT INFORMATION

Patients Legal Name: _____ Nick Name: _____ Birth Date: _____ Patients Age: _____

Patients Address: _____City: _____State: _____ Zip: _____Male: __ Female: __

Who referred you to our office: _____

PARENT OR GUARDIAN INFORMATION

Mothers Name: _____ Birth Date: _____ Mothers SSN: _____

Mothers Address: _____City: _____State: _____ Zip: _____Marital Status: _____

Employer: _____ Home #: _____ Cell #: _____

Work#: _____ Patient resides with mother: yes: ___ no: ___ E-mail Address: _____

Fathers Name: _____ Birth Date: _____ Fathers SSN: _____

Fathers Address: _____City: _____State: _____ Zip: _____ Marital Status: _____

Employer: _____ Home #: _____ Cell #: _____

Work#: _____ Patient resides with Father: yes: ___ no: ___ E-mail Address: _____

EMERGENCY CONTACT NOT IN THE HOME: _____ Cell: _____ Home: _____

If you are Legal Guardian accompanying patient, please give a copy of guardianship papers to the front desk and fill the above section out. Whom may we NOT discuss treatment with regarding this patient: _____

PRIMARY DENTAL INSURANCE OR MEDICAID INFORMATION- PHOTO IDENTIFICATION REQUIRED

Name of Insurance Company: _____ Address: _____ Phone #: _____

Group #: _____ ID #: _____ Insured Name: _____ Birth Date: _____

Insured Address: _____ SSN: _____ Employer: _____ Phone #: _____

SECONDARY INSURANCE OR MEDICAID INFORMATION- PHOTO IDENTIFICATION REQUIRED

Name of Insurance Company: _____ Address: _____ Phone #: _____

Group #: _____ ID #: _____ Insured Name: _____ Birth Date: _____

Insured Address: _____ SSN: _____ Employer: _____ Phone #: _____

I give Dentistry for Children permission to use Nitrous Oxide (laughing gas) and/or local anesthetic as needed to treat this patient. _____ yes _____ no

_____ _____

Signature of Parent or Guardian Date

I give Dentistry for Children permission to take necessary diagnostic films to properly make a complete diagnosis for treatment. _____ yes _____ no

_____ _____

Signature of Parent or Guardian Date

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

_____ _____

Signature of Parent or Guardian Date

PLEASE READ CAREFULLY AND CHECK ALL THAT APPLY, INCLUDE DATES AND SPECIFICS ABOUT A CONDITION. THIS INFORMATION WILL HELP OUR STAFF TREAT THE PATIENT COMPLETELY.

PATIENT NAME_____ DOB_____M/F_____ WEIGHT_____

PROBLEMS AT BIRTH: ___ NONE
___ Complications before or during birth, ___ Premature,___ birth defects, ___inherited conditions,___ growth and development issues
Explain_____

CARDIAC: ____NONE
___ Congenital heart defect, heart murmur ___Irregular heartbeat/palpitations, high blood pressure ___Abnormal ECHO
___ Premedication needed **Explain:** _____
_____

EAR, NOSE, THROAT: _____NONE
__Snoring, sleep apnea, excessive gagging ___Recent strep throat or respiratory infection ___Exposure to tobacco
___Impaired hearing, vision or speech **Explain**: _____
_____

PULMONARY: _____NONE
____ Asthma, reactive airway, breathing problems ___Recent bronchitis/pneumonia, RSV, croup___ Narrow airway
____Cystic fibrosis, tuberculosis **Explain**: _____
_____

GI/GU: ____ NONE
___ Acid reflux, GERD, stomach ulcer, intestinal problems, ___Hiatal hernia ___Hepatitis, jaundice ___Kidney or liver transplant, bladder problems ___Prolonged diarrhea, vomiting ____ Lactose or food intolerance **Explain**:_____
_____

NEUROLOGIC: ____NONE
__Seizures/epilepsy, cerebral palsy, brain injury __ Syncope/dizziness __Muscle paralysis or weakness __Recurrent or frequent headaches, fainting ____ Concussion **Explain**: _____
_____

MUSCULOSKELETAL: ____ NONE
___Arthritis, scoliosis, muscle joint problems ___ Neck movement problems __Muscular dystrophy, __low muscle tone ___ Fractures
Explain_____

PSYCHOSOCIAL: ____NONE
___Development disorders, learning delays ___ADD___ADHD ___Autism
Explain_____

ENDOCRINE/METABOLIC: _____NONE
___Diabetes, hyperglycemia, hypoglycemia ___Thyroid/pituitary ___Adrenal disorder ___Metabolic syndrome ___Precocious puberty or hormonal problems ___Growth Hormones **Explain:** _____
_____

BLOOD DISORDERS: ____ NONE
___Anemia _____ Sickle Cell ___ Bleeding disorder, Easy bleeding or bruising ___Leukemia ____ Transfusion ___Cancer, tumor, chemotherapy, radiation, bone marrow transplant **Explain:** _____
_____

OTHER: ___NONE
___Down syndrome _____ Pierre-Robin syndrome **Explain**: _____
___Hunters syndrome _____ Hurlers syndrome _____

PLEASE FILL OUT THE BACK SIDE ALSO

PLEASE LIST YOUR PRIMARY CARE DOCTOR AND ANY OTHER SPECIALISTS YOUR CHILD SEES:

NAME **PHONE NUMBER** **REASON**

_____

_____

PLEASE LIST ANY MEDICATIONS YOUR CHILD IS CURRENTLY TAKING: Dose and Reason

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IS YOUR CHILD ALLERGIC TO ANY FOODS, MEDICATIONS, ANESTHESIA, LATEX, and DYES OR METALS: If yes, please list.

_____

THIS CHILD IS CURRENT ON ALL THEIR IMMUNIZATIONS: ___YES ___NO. If no, please explain why.

Has there been any significant changes or disruptions in the patient's family, home or school routine? Yes___ No___ If yes please explain: _____

Is there anything about the patient's family medical or dental history we should be aware of? ___NO ___YES Explain_____

PATIENT ORAL HEALTH:

How would you describe the patient's?

Oral Health: Good:_____Fair:_____Poor:_____ Eating Habits: Good:____Fair:_____Poor:_____

Snacking Habits: Healthy: _____Mostly Sweet:_____ More than 2 times a day_____1 time a day or less____

Breath: Normal:_____Odor:_____ Sucking habits after age 1: thumb:_____Fingers_____Pacifer:_____

How often do you or the patient brush their teeth_____ Floss _____?

Does the patient participate in any sports_____ If so is a mouth guard worn_____

Has your child been treated by another dentist_____ If yes date of last visit_____ Reason for visit_____

X-rays taken _____.

Has your child had any tooth pain or mouth injury since their last visit? Yes____ No_____ If yes please explain_____

Is there anything else we should know or concerns you have, before treating your child? _____ if yes please explain_____

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

_____

Signature of Parent or Guardian Relationship Date

Initial Dr._____ Initial Staff_____