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_____