Patient History

Tell Us About Your Child

Today's Date:_____ Child's Home Phone #: _____ Social Security #:_____
Child's Name:_____ Child's Birthdate:____/____/____ Child's Age_____
Nickname:_____ ☐ Male ☐Female School:_____ Grade: _____
Child's Home Address:_____
Street City State Zip

Who is Accompanying the Child Today?

Name:_____ Relation:_____
Do you have legal custody of this child? ☐Yes ☐No Is the child adopted? ☐Yes☐ No
Is this child in a foster home? ☐Yes ☐ No Whom may we thank for referring you?_____
Other siblings seen by us:_____

Neighbor or relative not living with you

His/her name:_____ Relation:_____
Work Phone#:_____ Home Phone #:_____
Address:_____
Street City State Zip

Parent's Information

Parent's Marital Status: ☐ Married ☐ Divorced☐ Separated ☐ Widowed☐ Remarried ☐ Single

Mother: ☐ Step Mother ☐ Guardian Birthdate:____/____/____
Name:_____ Social Security #:_____
Home Phone #:_____ Work Phone#:_____ Cell #:_____
Address:_____
Street City State Zip
Employer:_____

Father: ☐ Step Father ☐ Guardian Birthdate:____/____/____
Name:_____ Social Security #:_____
Home Phone #:_____ Work Phone#:_____ Cell #:_____
Address:_____
Street City State Zip
Employer:_____

Person Responsible for Account

Name:_____ Relationship:_____ Social Security #:_____
Billing Address:_____
Street City State Zip
Work Phone #:_____ Home Phone #:_____
Employer:_____

Insurance Information

Dental Coverage? ☐Yes ☐No
Insurance Co. Name:_____ Phone #:_____Group # (Plan, Local or Policy #):_____
Insurance Co. Address:_____
PO Box/Street City State Zip
Policy Owner's Name:_____ Relationship to Patient:_____
Policy Owner's Birthdate:____/____/____ Social Security #/I.D. #:_____
Policy Owner's Employer:_____
Employer's Address:_____
Street City State Zip

Dental Coverage? ☐Yes ☐No
Insurance Co. Name:_____ Phone #:_____Group # (Plan, Local or Policy #):_____
Insurance Co. Address:_____
PO Box/Street City State Zip
Policy Owner's Name:_____ Relationship to Patient:_____
Policy Owner's Birthdate:____/____/____ Social Security #/I.D. #:_____
Policy Owner's Employer:_____
Employer's Address:_____
Street City State Zip

Dental History

Is the child currently in pain? ☐ **Yes** ☐ **No What is the primary reason for today's visit?**_____

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐**Yes** ☐ **No**

Has the child experienced problems with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No Is the child taking fluoride supplements? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No Floss his/her teeth daily? ☐ Yes ☐ No

Previous/Present Dentist:_____ Date of Last Visit:_____

Why did you leave your previous dentist? _____

What did you like the most about any dentist you have seen? _____

Least about? _____

Does / did the child have any of the following habits?

Y N	Breast Fed	Y N	Mouth Breather	Y N	Thumb/Finger Sucking
Y N	Chewing on Objects	Y N	Nail Biting	Y N	Tongue/Cheek Biting
Y N	Clenching/Grinding Teeth	Y N	Nursing Bottle Habits	Y N	Tongue Thrust
Y N	Lip sucking/Biting	Y N	Speech Problems	Y N	Used Pacifier

Medical History

Child's Physician:_____ Phone #:_____ Date of last visit:_____

Address:_____

Street City State Zip

Is the child currently under the care of a physician? ☐ Yes ☐ No Please Explain:_____

Please describe the child's current physical health: ☐ **Good** ☐ **Fair** ☐ **Poor** **Are immunizations current?** ☐ **Yes** ☐ **No**

Please list all drugs that the child is currently taking:_____

Please list all drugs and/or other things that cause the child allergic reactions:_____

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Has the child had/experienced any of the following:

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

Please discuss any serious medical problems the child experiences/ed:_____

Authorizations

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 child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian_____Date_____

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. My method of payment will be _____. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of parent or guardian_____Date_____

The parent or guardian who accompanies the child is responsible for payment at time of service.