RECORD NUMBER

FOR OFFICE USE ONLY

PATIENT NAME

Last _____ First _____ MI _____

Birth Date: (month/day/year)_____ Current Age: _____ Soc. Sec. # _____

Child's nickname: _____ Sex: _____ School: _____

Name of hobby, toy or playmate very special to your child (please specify): _____

Does your child live with both parents? ❑ Yes ❑ No ❑ Mother? ❑ Father? ❑ Guardian?

Child's Address: _____ City_____ State_____ Zip____

Father (or male guardian) Last _____ First _____ MI _____ DOB _____

Home Address: _____ City_____ State_____ Zip_____

❑ Employed ❑ Homemaker ❑ Student ❑ Retired ❑ Other _____ Soc. Sec. #: _____

Employed By: _____ City: _____ State:_____ Zip: _____

Present position: _____ How long held? _____ Work Phone: _____

Dental insurance company: _____ Effective Date: _____ Group Number: _____

If student, where? _____ Home Phone _____ Mobile number: _____

Mother (or female guardian) Last _____ First _____ MI _____ DOB _____

Home Address: _____ City_____ State_____ Zip_____

❑ Employed ❑ Homemaker ❑ Student ❑ Retired ❑ Other _____ Soc. Sec. #: _____

Employed By: _____ City: _____ State:_____ Zip: _____

Present position: _____ How long held? _____ Work Phone: _____

Dental insurance company: _____ Effective Date: _____ Group Number: _____

If student, where? _____ Home Phone _____ Mobile number: _____

Who is responsible for payment? _____ Phone number to call about appointments: _____

Method of payment for dental care: ❑ Payment in full at each appointment. ❑ Insurance or prepaid program.

We first learned about this dental office from: ❑ Phone Book/specify: _____ ❑ Website ❑ School ❑ Work

Referred by: ❑ Another patient, friend ❑ Another patient, relative ❑ Dental office doctor or staff member.

❑ Other _____ Name of person who referred us: _____

DENTAL HISTORY Is this your child's first visit to the dentist? ❑ Yes ❑ No

Last dental visit: _____ Purpose: _____ Last complete exam: _____

Has your child been having any specific problems? ❑ Yes ❑ No Describe: _____

Has your child experienced any unfavorable reaction from previous dental or medical care? ❑ Yes ❑ No Specify: _____

How do you describe your child's dental health? ❑ Good ❑ Fair ❑ Poor

Do you think your child has active dental disease: Decay? ❑ Yes ❑ No Gum Disease? ❑ Yes ❑ No

Childs home care: Brush? ❑ Yes ❑ No Floss? ❑ Yes ❑ No Other_____

Does your child's gums ever bleed? ❑ Yes ❑ No How often? _____ Does your child have bad breath? ❑ Yes ❑ No

Does your child have any bad mouth habits? ❑ Yes ❑ No Specify: _____

MEDICAL HISTORY (Confidential, Repeated every five years.)

Pediatrician/doctor's name: _____ Last Physical exam: _____

Does your child have any medical problems? ❑ Yes ❑ No Describe: _____

Is your child under a doctor's care now? ❑ Yes ❑ No If so, for what reason?: _____

Is your child taking any medication, pills or drugs? ❑ Yes ❑ No Please list: _____

Has your child ever had any of the following? Indicate YES with check mark (✓).

❑ Heat Disease	❑ Measles	❑ Tonsillitis	❑ Hepatitis	❑ Epilepsy	❑ Asthma
❑ Heart murmur	❑ Mumps	❑ Jaundice	❑ Prolonged bleeding	❑ Fainting spells	❑ Allgery to medicine/drugs
❑ Rheumatic fever	❑ Scarlet fever	❑ Kidney disease or dialysis	❑ Herpes	❑ Seizures or convulsions	❑ Allergy to anesthetics
❑ High blood pressure	❑ Typhoid fever	❑ Tuberculosis	❑ Aids	❑ Psychiatric treatment	❑ Allergy to foods
❑ Diabetes	❑ Chicken pox	❑ Arthritis	❑ Malignancies	❑ Prosthetic valves/joints	❑ Other allergies

List all of your child's allergies here: _____

Previous hospitalization or surgeries: _____

AUTHORIZATION: I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care to my child as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Child's Parent or Guardian Signature _____ Date _____

Reviewed by Doctor _____ Date _____

I have received a copy of Family Dental Services Notice of Privacy Practices.

Parent/Guardian Signature _____ Date _____

CHILD PATIENT INFORMATION • DENTAL AND MEDICAL HISTORIES

02/16