

**PATIENT INFORMATION**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name patient goes by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First

Age\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_ Sex F M School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name patient goes by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First

Age\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_ Sex F M School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name patient goes by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First

Age\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_ Sex F M School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name patient goes by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last Fir

Age\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_ Sex F M School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_

Home Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_**

**PARENT OR GUARDIAN INFORMATION \_\_\_\_MOTHER \_\_\_\_STEPMOTHER \_\_\_\_GUARDIAN**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_S.S. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred communication: \_\_\_ Email \_\_\_\_ Text \_\_\_\_\_ Cell Phone \_\_\_\_\_Home Phone

**PARENT OR GUARDIAN INFORMATION \_\_\_\_FATHER \_\_\_\_STEPFATHER \_\_\_\_GUARDIAN**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

S.S. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred communication: \_\_\_ Email \_\_\_\_ Text \_\_\_\_\_ Cell Phone \_\_\_\_\_Home Phone

**If insured, name of Dental Plan and Policy Number:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICAL HISTORY**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name patient goes by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First

Name of physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child currently have a health problem? \_\_\_Yes \_\_\_No

 Since when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is the problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any recent hospitalizations? \_\_\_\_Yes \_\_\_\_No

 When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ What was the problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child presently taking any medication? \_\_\_\_Yes \_\_\_\_No

Name of mediation(s) and dosages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child allergic to antibiotics or other medications? \_\_\_Yes \_\_\_No

Name of medication(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child allergic to or sensitive to LATEX? \_\_\_\_Yes \_\_\_\_No

Does your child have any other allergies? \_\_\_\_Yes \_\_\_\_No

 Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any of the following medical conditions your child has experienced:

**\_\_\_**Asthma \_\_\_Inhaler \_\_\_ Special Needs \_\_\_ Convulsions/Epilepsy

\_\_\_ Anemia \_\_\_ Heart Condition \_\_\_ HIV/AIDS \_\_\_ Hepatitis

 \_\_\_ Lung Disease \_\_\_ Ear Problems \_\_\_ Abnormal Bleeding \_\_\_ Nose/Throat Disorder

\_\_\_ Tubes in Ears \_\_\_ Blood Disease \_\_\_ Diabetes \_\_\_ Cancer/Tumors

 \_\_\_ ADD/ADHD \_\_\_ Tuberculosis \_\_\_ Stomach/Kidney Problems \_\_\_ Emotional Disorder

\_\_\_ Skin Disorder \_\_\_ Liver Problems \_\_\_ Latex Allergy \_\_\_ Seasonal Allergies

\_\_\_ Autism / Asperger’s Syndrome \_\_\_\_ Tonsils/Adenoids Removed \_\_\_ Speech/Vision Problems

\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain any medical condition(s) or concerns that your child has\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

Has your child ever been seen by a dentist? \_\_\_\_Yes \_\_\_No

If yes, please give the date of last dental care: \_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Dentist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had problems with previous dental treatment? \_\_\_Yes \_\_\_No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any type of injury to his/her teeth? \_\_\_Yes \_\_\_No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child in pain today? \_\_\_Yes \_\_\_No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have a dental condition about which you are especially concerned? \_\_\_Yes \_\_\_No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child eat between meals? \_\_\_\_Yes \_\_\_\_No

Does your child eat sweets, such as candy, soda pop, chewing gum? \_\_\_\_Yes \_\_\_\_No

 What\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child on a bottle? \_\_\_\_Yes \_\_\_\_No If no, at what age was it discontinued? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use “bottle water”? \_\_\_\_Yes \_\_\_\_No With or without fluoride? (Please circle one)

 If yes, do you use it for 1) drinking 2) cooking 3) both

Do you use community water (tap water)? 1) drinking 2) cooking 3) both 4) neither

Do you filter your tap water? \_\_\_\_Yes \_\_\_\_No Does the filter remove fluoride? \_\_\_\_Yes \_\_\_\_No

 Is your primary source of water from a well? \_\_\_Yes\_\_\_No

 If yes, have you had your well water tested for Fluoride content? \_\_\_\_Yes \_\_\_\_No

Is your child taking or using any Fluoride supplements (drops, tablets, rinses, gels)? \_\_\_\_Yes \_\_\_\_No

 If yes, what is being taken or used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When does your child brush his/her teeth? Upon rising Right after meals Before going to bed

Do you help your child with brushing his/her teeth? \_\_\_\_Yes \_\_\_\_No

Does your child floss? \_\_\_\_Yes \_\_\_No Do you help your child with flossing? \_\_\_\_Yes \_\_\_\_No

Does your child have any oral habits, such as thumb or finger sucking, pacifier use, nail biting, grinding, clinching, bottle feeding? \_\_Yes \_\_No

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age discontinued? \_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION & RELEASE**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child’s health. It is my responsibility to inform the dental office of any changes in my child’s medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_