



TODAYS DATE: _____

PATIENT

Name: _____ Prefers to be called: _____

DOB: _____ Age: _____ School/Grade: _____

Home Address: _____

RESPONSIBLIE PARTIES

Name(s): _____

Home Address: _____

Contact Phone: _____

Father's Employer: _____ Occupation: _____

Mother's Employer: _____ Occupation: _____

Email: _____

Parent's Marital Status: Married Divorced Separated Single Widowed

If divorced, who is the custodial parent? _____

Indicate which parent should receive correspondence: Mom Dad Both

DENTAL INSURANCE

Insurance Coverage: yes no Insurance Co: _____

Insured's Name: _____ Insured DOB: _____

Group #: _____ SSN/ID: _____ Phone #: _____

ADDITIONAL INFORMATION

Family Dentist: _____ Date of Last Cleaning: _____

Family Physician: _____ Date of Last Check-up: _____

Are there any siblings in the family? What are their ages? _____

What are some of your child's hobbies and interests? _____

How did you hear about our office? _____

What are your main concerns regarding your child's teeth? _____

How would you like us to contact you? Call Email Text

PLEASE ANSWER HEALTH HISTORY QUESTIONS ON THE BACK SIDE

Yes No

1.	Are you under a doctor's care at the present time?		
2.	Are you presently taking any medication regularly?		
3.	Have you ever been told you have a heart condition		
	Do you require any premedication before dental appointments?		
4.	Have you ever been told that your blood pressure is too high or too low?		
5.	Have you ever had rheumatic fever or rheumatic heart disease?		
6.	Do you bleed excessively following a cut or other injury?		
7.	Are you allergic to any food, drug, or medicine?		
	If so, please list :		
8.	Do you have other allergies?		
9.	Have you ever been treated for diabetes?		
10.	Have you ever been treated for epilepsy?		
11.	Have you ever been diagnosed with or treated for ADD, ADHD, OCD, Bipolar Disorder?		
12.	Have you ever taken Cortisone, ACTH, or other steroid drug?		
13.	Have you ever had a blood disease?		
14.	Have you ever had a bone disease, or more than one bone fracture?		
15.	Have you ever had a tumor or cancer?		
16.	Have you ever had surgery?		
17.	Have you had your tonsils and adenoids removed?		
18.	Have you ever had a disease of the eyes, ears, nose, or throat?		
19.	Have you ever experienced prolonged bleeding following a tooth extraction or oral surgery?		
20.	Have you ever experienced difficulty when dental anesthetics (Novocain) were administered?		
21.	Have you been diagnosed with having AIDS or AIDS-Related Complex?		
22.	Have you had any serious illness other than those mentioned?		
23.	Did you have any physical or genetic anomalies at birth?		
24.	Have you had any accidents or injuries relating to your face, teeth , or head?		
25.	Did you ever suck your thumb or fingers?		
26.	Have you ever had any other oral habits (nail biting, lip biting, cheek biting, etc.)?		
27.	Do you grind or clench your teeth?		
28.	Did your primary ("baby") teeth erupt on time (6-9 months of age)?		
29.	Has a dentist ever extracted any of your primary or permanent teeth?		
30.	Have you ever had:		
	a. Pain in your jaw joint when opening, chewing, or yawning?		
	b. Limited jaw movement?		
	c. Clicking or popping noises in your ears while chewing?		
	d. Your jaw get stuck open or closed?		
31.	Do you play any sports regularly?		
32.	Have you noticed any rapid growth in height recently?		

If any of the above questions are checked yes, please explain next to the question.

Parent's Signature