PATIENT INFORMATION

Name ______________________________
Last First MI

Address: ______________________________
____
City State Zip

Sex: ☐ Male ☐ Female **DOB:** __________

Home Phone: __________ **Work Phone:** __________

Cell Phone: __________ **Other Phone:** __________

E-Mail Address: ______________________________

Mother/Guardian Name: __________ **DOB:** __________

Father/Guardian Name: __________ **DOB:** __________

Who May We Thank For Referring You to Our Practice: ______________________________

What School Does Your Child Attend: ______________________________

PRIMARY DENTAL INSURANCE

Insurance Company:					
Insurance Company Phone:					
Group #		Policy #			
Policy Owner Name:		DOB:			
SSN:		Employer			
Policy Owner Employer:					

SECONDARY DENTAL INSURANCE

Insurance Company:					
Insurance Company Phone:					
Group #		Policy #			
Policy Owner Name:		DOB:			
SSN:		Employer			
Policy Owner Employer:					

DENTAL EXPERIENCE

This is my child's first dental visit		Yes		No
My child is worried about today's visit		Yes		No
My child's previous visits were not pleasant		Yes		No
My child had a toothache recently		Yes		No
When eating only OR keeps him/her up at night		Yes		No

DENTAL HEALTH AND HABITS

Please CHECK All that Apply

My child has regular dental exams & cleanings	
My child was breast/bottle fed for more than 1 year	
My child slept with a baby bottle or sippy cup	
What was in the bottle/cup:	
My child sucks a thumb or finger	
My child uses a pacifier	
My child is a mouth breather	
My child grinds or clenches teeth	
My child's gums bleed	
As a parent, are there any other dental concerns?	
Explain:	
What is the family's water supply:	
☐ Public Water ☐ Bottled/Distilled ☐ Well Water	
How often are your child's teeth brushed per day?	
How often are your child's teeth flossed weekly?	

MEDICAL HISTORY

Physician:		Phone #	

Please answer all questions by checking Yes or No

Are you Allergic to Any of the Following:	YES	NO
Food/Food Additives		
House Hold Items		
Latex Rubber		
Allergy to Drugs, Specify		

Please list All Medications You Are Currently Taking:

Please answer all questions by checking Yes or No	YES	NO
My Child Requires Antibiotics Prior to Dental Treatment:		
Abnormal Bleeding		
Artificial Bones/Joints/Valves		
Asthma		
Attention Deficit Disorder		
Autism		
Adenoids Removed		
Bladder Problems		
Blindness/Low Vision		
Blood Transfusion/Date:		
Bronchitis		
Chicken Pox		
Cerebral Palsy		
Chronic Earaches		
Circulation Problems		
Cancer/Chemotherapy/Radiation		
Type:		
Congenital Heart Defect		
Diabetes		
Down Syndrome		
Epilepsy/Seizures		
Fainting Spells		
Deafness/Hearing Loss		
Heart Murmur		
Heart Surgery		
Hemophilia		
Hospitalized for any Reason		
Hepatitis		
HIV+/AIDS		
Kidney Problems		
Leukemia		
Intellectual Disability		
Muscular Dystrophy		
Nervous Problems		

Please answer all questions by checking Yes or No	YES	NO
Pneumonia		
Rheumatic/Scarlet Fever		
Sickle Cell Disease/Traits		
Speech Problems		
Spina Bifida		
Stomach Problems		
Tonsillitis		
Tonsils Removed		
Tuberculosis (TB)		
Growth & Development		
Premature		
Birth Defects		
Concerns with Growth		
Communication Problems		
Psychological Problems		

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information I understand that providing incorrect information can be dangerous to my child's health. I authorize
The Dentist Place for Kids to release any information on my child to my insurance company.

____

Patient/Parent/Guardian Signature

Relationship to Patient: ______________________

Date: _______________

____

Doctor Signature

Date: _______________