

L D\_\_ BD\_\_

Date \_\_\_\_\_

A. GENERAL INFORMATION

PATIENT'S Name \_\_\_\_\_  
Last First MI Nickname

Date of birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Sex \_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_  
# to confirm appt.  
City State Zip

MOTHER'S Name \_\_\_\_\_ FATHER'S Name \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
City State Zip City State Zip

Mother's Phone #'s: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell: \_\_\_\_\_  
Father's Phone #'s: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell: \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_  
Social Security # \_\_\_\_\_ Social Security # \_\_\_\_\_

Names & Ages of Siblings: \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_

B. MEDICAL HISTORY

Has your child experienced problems with any of the following?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Cancer                    | <input type="checkbox"/> HIV Positive         |
| <input type="checkbox"/> to any Meds       | <input type="checkbox"/> Celiac disease            | <input type="checkbox"/> Jaundice             |
| <input type="checkbox"/> seasonal          | <input type="checkbox"/> Cerebral Palsy            | <input type="checkbox"/> Kidney/Liver disease |
| <input type="checkbox"/> tree or tree nut  | <input type="checkbox"/> Cold sores/fever blisters | <input type="checkbox"/> Lung problems        |
| <input type="checkbox"/> peanuts           | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Mental disorders     |
| <input type="checkbox"/> metal             | <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> Nervous disorders    |
| <input type="checkbox"/> latex             | <input type="checkbox"/> Fainting                  | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> dyes              | <input type="checkbox"/> Hearing disorder          | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Heart disorder            | <input type="checkbox"/> Speech disorder      |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> TB                   |
| <input type="checkbox"/> Autism            | <input type="checkbox"/> Hyperactivity or          | <input type="checkbox"/> Tonsils and Adenoids |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> attention deficit         | <input type="checkbox"/> Transfusions         |
|  |  | <input type="checkbox"/> Other                |

Please explain: \_\_\_\_\_

Has any immediate family member had any of the any of the above? \_\_\_\_\_ Please describe:

\_\_\_\_\_

Is your child taking any medication at this time? \_\_\_\_\_ If so, please list \_\_\_\_\_

Has your child ever been hospitalized? \_\_\_\_\_ Date(s), hospital(s), & details: \_\_\_\_\_

Has your child had any unfavorable reaction or allergy to any medication such as penicillin, aspirin, or novocain? \_\_\_\_\_ If so, please list \_\_\_\_\_

**Have you ever been advised by your physician that your child needs prophylactic antibiotics prior to dental treatment?** \_\_\_\_\_

Would you consider your child to be in good general health at the present time? \_\_\_\_\_ If not, please explain \_\_\_\_\_

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

### C. DENTAL HISTORY

Purpose of today's visit: \_\_\_\_\_

Is this your child's first visit to the dentist? \_\_\_\_\_

If not, give date of last visit to a dentist and service performed \_\_\_\_\_

Has your child ever complained about a dental problem, or had any unhappy dental experiences? \_\_\_\_\_

If so, please explain \_\_\_\_\_

Is your child presently having a dental problem? \_\_\_\_\_ If so, please explain \_\_\_\_\_

What is your main concern about your child's dental health? \_\_\_\_\_

Do you want complete dental treatment for your child? \_\_\_\_\_

Was your child breast fed? \_\_\_\_\_ Bottle fed? \_\_\_\_\_

Does your child have any of the following habits?

\_\_\_\_\_ thumb-sucking or finger-sucking \_\_\_\_\_ pacifier-sucking

\_\_\_\_\_ night-time grinding \_\_\_\_\_ nail biting

\_\_\_\_\_ other \_\_\_\_\_

Does your child have any missing or lost teeth? \_\_\_\_\_

Has your child ever worn orthodontic appliances? \_\_\_\_\_

How often are your child's teeth brushed? \_\_\_\_\_ flossed? \_\_\_\_\_

Is your child assisted in brushing? \_\_\_\_\_

Is your water fluoridated? Home \_\_\_\_\_ Daycare \_\_\_\_\_ School \_\_\_\_\_

Name of school your child attends \_\_\_\_\_

Do you or have you given your child any form of fluoride? \_\_\_\_\_

Has your child inherited any dental conditions? \_\_\_\_\_ If so, please explain \_\_\_\_\_

How would you expect your child to behave in our office? \_\_\_\_\_

Thank you for your help. If there is any information that you feel might be of value to us in the treatment of your child, please add it here: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian