Date:______________________

PLEASE PRINT

Personal History

Child's Name:_________________________________Sex__________Referred by____________________________
First Last

Child's Age_____________Child's Weight____________Birthday__________________Nickname______________________
Month/Day/Year

Hobbies,Pets, Favorite T.V. Shows, etc.____

(circle one)
Responsible Party: Dr. Mr. Mrs. Ms. Miss_________________________________Date of Birth__________SS#_____________
(name)

Address:____Phone#___________________________
Number Street City/State Zip

CELL#____________________________

Employer:____Employer Phone#:______________________

Employer Address:____
Number Street City/State Zip

(circle one)
Parent 2: Dr. Mr. Mrs. Ms. Miss__________________________________Date of Birth_____________SS#_______________
(name)

Address(if different):____Phone#_______________________
Number Street City/State Zip

CELL#__________________________

Employer:____Employer Phone#:____________________

Employer Address:____Can we call________________________
Number Street City/State Zip you at work?

EMAIL ADDRESS: ____________________________________(to be used only for appointment related information)

Other Children in Family____

INSURANCE INFORMATION

If you have *dental insurance* coverage for your child, please complete below:

Insurance 1:____
Insurance Company Name Group#

Address____
Insurance Company Address Phone Number

Insurance 2:____
Insurance Company Name Group #

Address____
Insurance Company Address Phone Number

Authorization to Release Information:
I hereby authorize the above named dentist(s) to provide any insurance company(s), claims administrative(s) and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluation and administering claims for benefits. I am aware that I am financially responsible for any charges not covered by my insurance carrier.

____
Parent/Legal Guardian/Foster parent Signature Date

(PLEASE COMPLETE OTHER SIDE)

Dental History

Reason for visit (1st Examination, Check-Up, Toothache, etc.):______________________________

How long since last visit to a dentist? ______________________________

Was your child's last dental experience pleasant or unpleasant?______________________________

Does he/she object to anything in particular? ______________________________

Medical History

Name of Pediatrician:____________________City:__________Phone#____________

Name of Pharmacy: ____________________ Phone# ____________________

Does your child have any allergies?______________________________

Is your child taking medication?______________For what reason?______________

Has your child ever had a reaction to any medication, such as penicillin, aspirin, etc.?______________

What type of reaction? ______________________________

Has your child ever been a patient in a hospital or emergency room?________If yes, for what reason?______________

____

Does your child have any emotional, mental or nervous issues?______________________________

____

Please check if your child has had any of the following. If so, at what age?

____ Heart Disease	____ Endocrine Disorders	____ School Problems	____ **NONE**
____ Heart Murmur	____ Hepatitis	____ Anxiety Disorder	
____ Heart Condition	____ Tuberculosis	____ ADD/ADHD	
____ Kidney Disease	____ Rheumatic Fever	____ Autism Spectrum Disorder	
____ Liver Disease	____ Chicken Pox	____ PDD	
____ Diabetes	____ Mumps	____ Speech Disorders	
____ Bleeding Disorders	____ Measles	____ Congenital Birth Defects	
____ High Blood Pressure	____ Convulsions/Seizures	____ Cerebral Palsy	
____ Sickle Cell	____ Anemia	____ **OTHER**	
____ Epilepsy	____ Asthma	______________________	
____ Hemophilia	____ HIV/AIDS	______________________	

Is your child up to date with his/her immunizations? _____YES _____NO

Has anyone in the immediate (patient's mother, father or siblings) family ever had any of the following?
____ Diabetes ____ Heart Disease ____ Cancer ____ Tuberculosis ____ Bleeding Problems ____ None

____

Signature of Parent / Legal Guardian / Foster Parent

Please circle your relationship to the patient:

Parent **Legal Guardian** (please provide supporting documents) **Foster Parent** (please provide supporting documents)

IT IS THE OFFICE POLICY THAT THE PARENT/GUARDIAN ACCOMPANYING THE CHILD WILL BE FINANCIALLY RESPONSIBLE FOR ALL TREATMENT RENDERED.

COMMENTS: