PATIENT INFORMATION

Last Name_____ First Name_____ MI_____

Nickname_____ Birthdate_____ Male Female

Address _____ City_____ State_____ Zip_____

Does patient live with Father / Mother / Guardian or Other_____

Reason for Visit_____

How did you hear about us or whom may we thank for referring you?_____

Other family members treated in our office_____

FAMILY INFORMATION

Father / Step-Father / Guardian (please circle)

Last Name_____ First Name_____ MI_____

Birthdate_____ Social Security #_____ Email_____

Address _____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Business Phone_____

Employer _____ Occupation_____

Mother / Step-Mother / Guardian (please circle)

Last Name_____ First Name_____ MI_____

Birthdate _____ Social Security #_____ Email_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Business Phone_____

Employer _____ Occupation_____

In case of emergency, please list someone other than those above who will know how or where to contact you.

Name_____ Relationship_____

Address_____ Phone Number(s)_____

INSURANCE INFORMATION

Is the patient covered under a group or private dental insurance plan? Yes No If yes, please complete a Signature on File form.

Is the patient covered under Medicaid? Yes No State_____ Patient's ID#_____

Patient Last Name_____ First Name_____ DOB_____

DENTAL INFORMATION

Is this your child's first dental visit? Yes No Previous Dentist_____ Last Visit _____

Have there been any injuries to your child's teeth or jaw? (falls, blows, chips)_____

Has your child experienced any unfavorable reaction from previous dental care? Yes No Explain_____

_____

Does your child have a history of ___ Lip Sucking ___Mouth Breathing ___Thumb Sucking ___Nail Biting ___Pacifier ___Finger Sucking

How often does your child brush?_____ Does your child floss? Yes No

Is your child's brushing supervised? Yes No If yes, by whom? _____

Does your child receive ____ Fluoride in Vitamins ____ Fluoride Tablets/Drops ____Fluoride Water ____None

How do you think your child will act toward the dentist?_____

Name of Family Dentist_____ City_____

MEDICAL INFORMATION

List all medications your child is taking_____

List all allergies your child has_____

Name of Pharmacy_____ City_____

Patient's Physician _____ City_____

Please check if your child has a history of any of the following:

___Heart Trouble or Murmurs If so, is a pre-medication antibiotic needed for dental treatment? _____

___Drug Sensitivities/Allergies If so, please list_____

___Born Premature If so, patient was born at _____weeks

___Asthma	___Diabetes	___Brain Injury	___Hepatitis
___Respiratory Problems	___Kidney Concerns	___ADD	___Bleeding Problems
___Epilepsy	___Liver Concerns	___ADHD	___Blood Disorders
___Seizures / Convulsions	___Cancer	___Developmentally Delayed	
___MRSA	___HIV / AIDS	___Autism	

List any additional medical concerns _____

_____

_____ **My child does not have any health concerns**

I hereby authorize the Drs. of Children's Dental Center P.C. to perform any and all treatment for my above named child and consent to such methods, medications, and agents as may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled by either party. I will be responsible for the cost of the dental care. Payment is expected at time of treatment. Payment options include cash, check, money order, Visa, Mastercard, Discover or Care Credit.

_____ _____ _____

Signature Relationship to Child Date