WELCOME TO OUR OFFICE

DATE:___________________________

CHILD'S NAME____ NICKNAME__________________________ SEX________________

BIRTHDATE_____________________ AGE_____ FATHER/PARENT OR LEGAL GUARDIAN____

MOTHER/PARENT OR LEGAL GUARDIAN____

BILLING ADDRESS IF DIFFERENT THAN CHILD 'S_____________________________ CITY_________________ STATE________ ZIP_________

PRIMARY DENTAL INSUR. CO.____ SUBSCRIBER____

SUBSCRIBER'S EMPLOYER____ SUBSCRIBER'S BIRTHDATE____________________________

SUBSCRIBER'S ID# (Do NOT e-mail if SSN) ____ POLICY/GROUP # ______________________

SECONDARY DENTAL INSUR. CO.____________________________________ SUBSCRIBER____

SUBSCRIBER'S EMPLOYER____ SUBSCRIBER'S BIRTHDATE____________________________

SUBSCRIBER'S ID# (Do NOT e-mail if SSN)____ POLICY/GROUP # ______________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?____

MEDICAL HISTORY

YES **NO** **FOR DOCTOR'S USE**

Former Dentist____

City____ State_________________

Please list any dental concerns____

Date of last dental visit______________________ Last x-rays____________________

Has your child sustained any injuries to the mouth, teeth, or head?

If yes, please describe:____

Has your child ever been exposed to nitrous oxide (laughing gas)?

How often are your child's teeth brushed?_____________________________________

How often are your child's teeth flossed?______________________________________

Is your child regularly exposed to fluoride ___ (listed below)?

water? ....

tablets?..

toothpaste?..

at dental office visits?.. ☐

Do you have any specific questions regarding your child's dental care?

____

____

____

Has your child been treated by a physician in the last five years?

For what reason?____

Has your child gained/ lost more than 10 pounds in the last three months?

Do they take any medications/herbs (prescribed or over-the-counter)?

Drug Dose Purpose

____

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____

	YES	NO	FOR DOCTOR'S USE
Are they allergic to any medications or substances (such as latex, metals, iodine, etc.)? Please list:			

____

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____

____

Please list hospitalizations and/or surgeries:

Date: Procedure:

____

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	HAS YOUR CHILD EVER EXPERIENCED ANY OF THE FOLLOWING:	YES	NO	FOR DOCTOR'S USE
1	Congenital birth defects, heart or otherwise	☐		
2	Rheumatic fever			
3	Heart murmur	☐		
4	High blood pressure	☐		
5	Asthma	☐		
6	Tuberculosis	☐		
7	Liver disease–hepatitis, jaundice			
8	Kidney disease	☐		
9	Seizures, convulsions, epilepsy	☐		
10	Loss of consciousness	☐	☐	
11	Excessive bleeding when injured	☐	☐	
12	Thyroid gland disease	☐	☐	
13	Diabetes	☐	☐	
14	Malignancy, cancer	☐	☐	
15	Chemotherapy or Radiation Therapy	☐	☐	
16	Artificial joint, valve or prosthesis surgically implanted	☐	☐	
17	HIV, AIDS, or exposure to the AIDS Virus	☐	☐	

Signed____

Date____

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Updated____

Summary____