Patient Information

Patient: Date:

Name child would like to be called: Birthday: Age: Gender:

Address: City: Zip:

Email: Home Phone: Cell Phone:

School: Grade:

Name and ages of other children in the family:

Mother: Mother's Employeer:

Social Security #: Work Phone:

Father: Father's Employeer:

Social Security #: Work Phone:

Who has legal custody of patient?:

Person responsible for payment of account?: Date of Birth:

Whom may we thank for referring you?:

What is the reason foryour child's dental visit?:

Insurance Information

Name of Insured: Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: Insurred Date of Birth:

Insured Policy #: Insured Group Number:

Employer: Insurance Company:

Address: Insurance Address:

Address 2: Insurance Address 2:

City, State, Zip: City, State, Zip:

Phone Number: Phone Number:

Health History

☐ Yes ☐ No Is your child in good health? Name of child's physcian:

Date of last physcian exam:

☐ Yes ☐ No Has your child ever had a health problem?

☐ Yes ☐ No Are your child's immunizations up-to-date?

☐ Yes ☐ No Has your child had any operations?

☐ Yes ☐ No Is your child currently on any medications?

☐ Yes ☐ No Were there any problems at birth?

☐ Yes ☐ No Is your child allergic to anything?

Check all that apply:

☐ AIDS/HIV	☐ Diabetes	☐ Hepatits	☐ Tuberculosis	☐ Mental Delays
☐ Anemia	☐ Epilepsy / Seizures	☐ Kidney Disease	☐ Congenital Birth Defects	☐ Physical Delays
☐ Asthma	☐ Excessive Bleeding	☐ Liver Disease	☐ Cerbral Palsy	☐ Social Delays
☐ Blood Disorder	☐ Frequent Headaches	☐ Rheumatic Fever	☐ Cleft Lip/Palate	☐ Speech Problem
☐ Cancer/Tumors	☐ Heart Murmur	☐ Stomach / GI Disease	☐ Frequent Infections	☐ Heart Condition
☐ Sickle Cell	☐ Latex Allergy	☐ Sleep Apnea	☐ Penicillian Allergy	☐ Other

Please elaborate on any items checked:

Do you consider your child to be?:
- ☐ Advanced in the learning process
- ☐ Progressing normally
- ☐ Slow in the learning process

Dental History

☐ Yes ☐ No Has your child ever been to the dentist? Date of last dental visit?:

☐ Yes ☐ No Has your child ever had dental x-rays? Date:

☐ Yes ☐ No Do you think your child will react well to dental treatment? Explain:

☐ Yes ☐ No Does your child suck a finger, thumb, or pacifier? Ages when?:

☐ Yes ☐ No Does your child use dental floss? How often?:

☐ Yes ☐ No Does your child have snacks between meals?:

☐ Yes ☐ No Have your child's teeth been injured? When?Which teeth?:

Treatment?:

☐ Yes ☐ No Does your child's jaw make noise and is pain associated with the sounds?:

Please check if your child is having problems with any of the following:

☐ Cavities ☐ Toothache ☐ Sensitive Teeth ☐ Surgical Mouth Treatment

☐ Gum Infections ☐ Color of Teeth ☐ Orthodontics ☐ Jaw Sounds

☐ Other

Comments:

Fluoride History

☐ Yes ☐ No Is your home water supply fluoridated?

☐ Yes ☐ No Does your child use fluoride toothpaste?

☐ Yes ☐ No Does your child use fluoride supplements? Dose: ☐ 0.25mg ☐ 0.50mg ☐ 1.0mg

☐ Yes ☐ No Do you give your child any other forms of fluoride?

What?

Consent for Dental Treatment

I request and authorize Dr. Smith and her staff to examine, clean, and provide my child with comprehensive dental treatment including fillings, crowns, extractions, and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Smith to diagnose and/or treat my child's dental condition. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purpose. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment by using praise, explanation, and demonstraton of procedures and instruments, and using variable voice tone.
I understand that I will be responsible for any charges incurred on this child for dental treatment.

Signature: ______________________ Date: ______________