PATIENT NAME_____

Child's nickname:_____ Sex:_____ School:_____
Name of hobby, sport, toy or playmate very special to your child (please specify):_____
Does child live with both parents? ☐ Yes ☐ No ☐ Mother? ☐ Father? ☐ Guardian?
Child's address:_____ Zip Code_____ Soc. Sec.#_____
Father (or male guardian) complete name:_____ Birthdate:_____
Home address (if different from child's)_____ Home phone:_____
☐ Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other_____ Soc. Sec.#_____
Employed by:_____ City:_____ State:_____ Zip:_____
Present position:_____ How long held?_____ Work phone:_____
Dental insurance company:_____ Group number:_____
If student, where?_____
Mother (or female guardian) complete name:_____ Birthdate:_____
Home address (if different from child's)_____ Home phone:_____
Employed by:_____ City:_____ State:_____ Zip:_____
Present position:_____ How long held?_____ Work phone:_____
Dental insurance company:_____ Group number:_____
If student, where?_____
Who is responsible for payment?_____ Phone number to call about appointments:_____
Method of payment for dental care: ☐ Payment in full at each appointment. ☐ Insurance or prepaid program.
We first learned about this dental office from: ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work
Referred by: ☐ Another patient, friend ☐ Another patient, relative. ☐ Dental office doctor of staff member.

☐ Other_____ Name of person who referred us:_____

DENTAL HISTORY Is this your child's first visit to the dentist? ☐ Yes ☐ No
Has your child been having any specific problems? ☐ Yes ☐ No Describe:_____
Last Dental visit:_____ Purpose:_____ Last complete exam:_____
Has your child experienced any unfavorable reaction from any previous dental or medical care? ☐ Yes ☐ No Specify:_____
How do you describe your child's dental health? ☐ Good ☐ Fair ☐ Poor
Do you think your child has active dental disease: Decay? ☐ Yes ☐ No Gum Disease? ☐ Yes ☐ No
Child's home care: Brush? ☐ Yes ☐ No Floss? ☐ Yes ☐ No Other?_____
Does your child's gums ever bleed? ☐ Yes ☐ No How often?_____ Does your child have bad breath? ☐ Yes ☐ No
Does your child have any bad mouth habits? ☐ Yes ☐ No Specify:_____

MEDICAL HISTORY (Confidential. Repeated every five years.) BIRTHDATE MONTH/DAY/YEAR_____
Pediatrician/doctor's name:_____ Last Physical exam:_____ Current age:_____
Does your child have any medical problems? ☐ Yes ☐ No Describe:_____
Is your child under a doctor's care now? ☐ Yes ☐ No If so, for what reason?_____
Is your child taking any medications, pills or drugs? ☐ Yes ☐ No Please list:_____
Has your child ever had any of the following? Indicate YES with check mark (✓).

☐ Heart Disease.	☐ Measles.	☐ Tonsillitis.	☐ Hepatitis.	☐ Epilepsy.	☐ Asthma.
☐ Heart Murmur.	☐ Mumps.	☐ Jaundice.	☐ Prolonged Bleeding.	☐ Fainting spells.	☐ Allergy to medicines/drugs.
☐ Rheumatic Fever.	☐ Scarlet fever.	☐ Kidney disease or dialysis.	☐ Herpes.	☐ Seizures or convulsions	☐ Allergy to anesthetics.
☐ High blood pressure.	☐ Typhoid fever.	☐ Tuberculosis.	☐ AIDS.	☐ Psychiatric treatment.	☐ Allergy to foods.
☐ Diabetes.	☐ Chicken Pox.	☐ Arthritis.	☐ Malignancies.	☐ Prosthetic valves/joints.	☐ Other allergies.

List all your child's allergies here:_____ List Hospitalizations:_____

AUTHORIZATION: I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Child's Parent or Guardian Signature/Date: X_____ Reviewed by Doctor Date: X_____

FOR OFFICE USE ONLY
B/P_____

MEDICAL HISTORY UPDATES FOR SUBSEQUENT VISITS
I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PARENT/GUARDIAN SIGNATURE	B.P.	REVIEWED BY
_____	_____	None ☐	_____	_____	DR._____
_____	_____	None ☐	_____	_____	DR._____
_____	_____	None ☐	_____	_____	DR._____
_____	_____	None ☐	_____	_____	DR._____
_____	_____	None ☐	_____	_____	DR._____