

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 _____

PHONE _____ EMAIL ADDRESS _____

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

YES NO FOR DOCTOR'S USE

Are they allergic to any medications or substances (such as latex, metals, iodine, etc.)? Please list:

Please list hospitalizations and/or surgeries:

Date: _____ Procedure: _____

HAS YOUR CHILD EVER EXPERIENCED ANY OF THE FOLLOWING: Congenital YES NO FOR DOCTOR'S USE

- 1 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 _____

Provider Signature _____ Date _____

Updated _____

Summary _____

