

PATIENT NAME: _____ BIRTH DATE: (Month/Day/Year) _____

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: _____ Soc.Sec.# _____

Father (or male guardian) complete name: _____

Home address (if different from child's) _____ Home phone: (____) _____

Employed Homemaker Student Retired Other _____ Soc.Sec.# _____

Employed by: _____ City: _____ State: _____ Zip: _____

Work phone: (____) _____ Dental insurance company: _____ Group #: _____

Mother (or female guardian) complete name: _____

Home address (if different from child's) _____ Home phone: (____) _____

Employed Homemaker Student Retired Other _____ Soc.Sec.# _____

Employed by: _____ City: _____ State: _____ Zip: _____

Work phone: (____) _____ Dental insurance company: _____ Group #: _____

Who is responsible for payment? _____ Phone number to call about appointments: (____) _____

Method of payment: Payment in full at each appointment. Insurance or prepaid program. Monthly budget payments.

We first learned about this dental office from: Yellow Pages Newspaper School Work

Referred by: Friend Relative Another patient Dental office doctor or staff member Other _____

Name of referring person: _____

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.) BIRTH DATE: (Month/Day/Year) _____

Pediatrician / doctor's name: _____ Last current 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 (✓).

- | | | | | | |
|--|--|---|---|---|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Measles | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Mumps | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Allergy to medicine/drugs |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Kidney disease or dialysis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Seizures or convulsions | <input type="checkbox"/> Allergy to anesthetics |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Typhoid fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Aids | <input type="checkbox"/> Psychiatric treatment | <input type="checkbox"/> Allergy to foods |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Prosthetic valves/joints | <input type="checkbox"/> Other allergies |

List all of your child's allergies here: _____

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 of my child 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.

X _____ X _____

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

MEDICAL HISTORY UPDATES FOR SUBSEQUENT VISITS

I have read my child's MEDICAL HISTORY dated _____, and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PARENT/GUARDIAN SIGNATURE	REVIEWED BY
_____	_____	None <input type="checkbox"/> _____	DR. _____
_____	_____	None <input type="checkbox"/> _____	DR. _____
_____	_____	None <input type="checkbox"/> _____	DR. _____
_____	_____	None <input type="checkbox"/> _____	DR. _____
_____	_____	None <input type="checkbox"/> _____	DR. _____
_____	_____	None <input type="checkbox"/> _____	DR. _____