PATIENT INFORMATION

Child's Legal Name _____ Nickname _____

Sex ____ Age _____ Date of Birth _____/_____/_____ Home Phone _____

Home Address _____
Street City Zip

Patient lives with: Both Parents / Mother / Father / If child does not live with both parents, give name of legal custodian (and relation): _____

Any custody issues our office needs to be aware of? ☐ yes ☐ no

Father's Name _____ Date of Birth _____/_____/_____

Cell Phone # _____ Carrier _____ Email Address _____

Address _____

Diver's License Number _____ Social Security Number _____

Employed By _____ Dental Insurance Carrier _____

Employer's Address _____ Business Phone _____

Mother's Name _____ Date of Birth _____/_____/_____

Cell Phone # _____ Carrier _____ Email Address _____

Address _____

Driver's License Number _____ Social Security Number _____

Employed By _____ Dental Insurance Carrier _____

Employer's Address _____ Business Phone _____

Our office must have phone number(s) in case of emergency and/or the parents are unavailable; a message number:

_____ | _____
Name Number Relation Name Number Relation

Whom may we thank for referring you to our office: _____

Purpose of this visit _____ Name of Family Dentist _____

Has the child had any previous dental treatment? ____ With whom? _____ Approx. date _____

Child's Physician (Medical Doctor): _____
Name City

Date of last physical exam: _____

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PATIENT INFORMATION & HEALTH HISTORY UPDATES

Date	Addition or change	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEALTH HISTORY

(please circle the appropriate answer)

1. Was your child ever a patient in a hospital? ..... YES NO
2. Is your child now under medical care? ..... YES NO
3. Is your child taking medication now? ..... YES NO
   If yes, for what? _____
   Name of medication _____
4. Has your child ever had a serious illness or operation? .. YES NO
   If yes, explain: _____
5. Does your child have (or ever had) any of the following?
   a. Rheumatic fever or Scarlet fever ..... YES NO
   b. Congenital heart disease ..... YES NO
   c. Cardiovascular disease (heart trouble, heart surgery or heart murmur) ..... YES NO
   d. Allergy? Food / Medicine / Other ..... YES NO
   e. Asthma or Hay Fever ..... YES NO
   f. Hives or a skin rash ..... YES NO
   g. Fainting spells or seizures ..... YES NO
   h. Hepatitis, jaundice or liver disease ..... YES NO
   i. Diabetes ..... YES NO
   j. Inflammatory rheumatism (painful swollen joints) .... YES NO
   k. Arthritis ..... YES NO
   l. Stomach ulcers ..... YES NO
   m. Kidney problems ..... YES NO
   n. Tuberculosis (TB) or lung problems ..... YES NO
   o. Cancer, tumor, leukemia ..... YES NO
   p. Vision problems ..... YES NO
   q. Epilepsy or Seizures ..... YES NO
   r. Sickle Cell disease ..... YES NO
   s. Thyroid disease ..... YES NO
   t. HIV infection or AIDS ..... YES NO
   u. Emphysema ..... YES NO
   v. Psychiatric treatment or counseling ..... YES NO
   w. Cleft lip / palate ..... YES NO
   x. Cerebral palsy ..... YES NO
   y. Learning disability ..... YES NO
   z. Hearing or Speech disability ..... YES NO
   aa. Developmental disability or cerebral palsy ..... YES NO
   If yes, explain _____
   bb. Was your child premature? ..... YES NO
   If yes, how many weeks? _____
   cc. Congenital birth defects ..... YES NO
   dd. Other _____
6. Has your child had abnormal bleeding associated with previous surgery, extractions or accidents? ..... YES NO
7. Does your child bruise easily? ..... YES NO
8. Has your child ever required a blood transfusion? ..... YES NO
9. Does your child have any blood disorders such as hemophilia? ..... YES NO
10. Has your child ever had surgery, x-ray or chemotherapy for a tumor, growth, or other conditions? ..... YES NO
11. Is your child presently taking any of the following?
    a. Antibiotics or sulfa drugs ..... YES NO
    b. Anticoagulants (blood thinners) ..... YES NO
    c. Medicine for high blood pressure ..... YES NO
    d. Cortisone or steroids ..... YES NO
    e. Tranquillizers ..... YES NO
    f. Aspirin ..... YES NO
    g. Dilantin or other anticonvulsant ..... YES NO
    h. Insulin tolbutamide, Orinase, or similar drug ..... YES NO
    i. Fluoride supplements ..... YES NO
    j. List current medications: _____
    _____
12. Is your child allergic to, or ever reacted adversely
    a. Local anesthetics ..... YES NO
    b. Penicillin or other antibiotics ..... YES NO
    c. Sulfa drugs ..... YES NO
    d. Aspirin ..... YES NO
    e. Rubber or latex ..... YES NO
    f. Any Other: _____
13. Has your child had any serious trouble associated with any previous dental treatment? ..... YES NO
14. Has your child ever had orthodontic treatment (worn braces)? ..... YES NO
15. Has your child ever been treated for any gum diseases (gingivitis, periodontitis, pyorrhea)? ..... YES NO
16. Do your child's gums bleed when brushing teeth? ..... YES NO
17. Does your child grind or clench teeth? ..... YES NO
18. Has your child had toothaches? ..... YES NO
19. Has your child had frequent sores in or around this/her mouth? ..... YES NO
20. Has your child had any injuries to his/her mouth or jaws? ..... YES NO
21. Does your child have any sores or swellings of his/her mouth? ..... YES NO
22. Have you been satisfied with your child's previous dental care? ..... YES NO

ADOLESCENT WOMEN:

23. Are you pregnant now, or think you may be? ..... YES NO
24. Do you anticipate becoming pregnant? ..... YES NO
25. Are you taking birth control pills? ..... YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or his/her medicine changes, I will inform the doctor at the next appointment without fail. This information will be held in the strictest of confidence. I consent to a diagnostic examination, to include x-rays if necessary.

Parent or Guardian's Signature: _____ Date _____