

Date _____

PATIENT INFORMATION *Answers to all Questions are for Office Use and Strictly Confidential*

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ Zip Code _____

Sex: M F Birthdate ____/____/____ SS Number _____

Previous General Dentist (Name, Address & Phone Number) _____

Reason For Changing Dentist _____

PARENTS INFORMATION

Fathers Name _____ SS Number _____ Birthdate ____/____/____

Cell Phone _____ Occupation _____ Employed By _____

Business Address _____ Business Phone _____

Mothers Name _____ SS Number _____ Birthdate ____/____/____

Cell Phone _____ Occupation _____ Employed By _____

Business Address _____ Business Phone _____

Nearest Friend or Relative (Name & Phone Number) _____

How Did You Here About Our Office Friends Family Website Phone Book Location Other _____

INSURANCE INFORMATION

Who Is Responsible For Account _____

Dental Insurance Company _____ Subscriber _____

Insurance ID Number _____ Group Number _____

MEDICAL HISTORY

1. Medical Doctor (Name, Address & Phone Number) _____

2. Is Your Child In Good Health? Yes No Explain: _____

3. Has He / She Had A Physical Exam In The Last Year? Yes No Date: _____

4. Is Your Child Now Under Medical Care? Yes No Why: _____

5. Is He / She Taking Any Medications, Supplements or Drugs? Yes No What: _____

6. Is He / She Allergic To Any Medications or Substances? Yes No What: _____

7. Is The Patient Pregnant? (Adolescent Woman) Yes No Due Date: _____

MARK AN X IN THE BOX IF YOU HAVE HAD ANY OF THE FOLLOWING

- | | | | | | |
|--|--|---|--|---|---|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Chemotherapy / Radiation | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hives or Skin Rash | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis / Gout | <input type="checkbox"/> Aids / HIV |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Fainting Of Dizziness | <input type="checkbox"/> Hearing Disability | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis A (Infect.) | <input type="checkbox"/> Pain In Jaw Joints | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Epilepsy Or Seizures | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hemophilia | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> X-ray Or Cobalt Tmt. | <input type="checkbox"/> Psychiatric Care | |

8. Have You Ever Had Any Other Serious Illness Or Condition Not Marked Above? Describe In Detail: _____ Yes No

DENTAL HISTORY

- 1. Does Your Child Have A Specific Dental Problem? Describe: _____ Yes No

- 2. Does Your Child Have Dental Examinations On A Routine Basis? Date of Last Visit: _____ Yes No
Last X-Rays: _____ Last Fluoride Tx: _____ Last Cleaning: _____
- 3. Would You Describe Their Present Dental Health As Good? Comments: _____ Yes No

- 4. Has He / She Been Treated For Any Gum Diseases (Gingivitis, Periodontitis, Trench Mouth, Pyorrhea)? _____ Yes No
- 5. How Often Does He / She Brush? _____ Floss? _____ Use Mouth Rinses? _____ Yes No
- 6. Does He / She Feel Nervous About Having Dental Treatment? _____ Yes No
- 7. Has He / She Ever Had A Bad Experience In A Dental Office? Describe: _____

- 8. Does He / She Ever Brux Or Grind Your Teeth? Discuss: _____ Yes No
- 9. Has He / She Ever Had Orthodontic Treatment (Tooth Straightening)? _____ Yes No
- 10. Does He / She Ever Have Clicking, Popping Or Discomfort In The Jaw Joints (TMJ)? _____ Yes No
Please Discuss: _____
- 11. Has He / She Had A Root Canal Or Pulpotomy Treatment? _____ Yes No
- 12. Has He / She Ever Lost A Tooth Due To An Accident Or Decay? _____ Yes No
- 13. Has He / She Often Had Toothaches? _____ Yes No
- 14. Has He / She Had Frequent Sores In His / Her Mouth? _____ Yes No
- 15. Has He / She Had Any Injuries To His / Her Mouth Or Jaw? _____ Yes No
- 16. Has He / She Ever Had A Thumb Sucking Habit Or Used A Pacifier? _____ Yes No
- 17. Does He / She Use Tobacco? What Type? _____ Yes No
- 18. Does He / She Frequently Snack On Sweets, Chew Gum Or Drink Pop? _____ Yes No
- 19. What Has Been Used For Comfort In Previous Dental Treatment? Local Anesthetic N₂O Gas Neither Yes No
- 20. Has He / She Had A Reaction To Dental Anesthetic? _____ Yes No
- 21. Has He / She Been Told They Need To Be Pre-Medicated For Dental Treatment? _____
- 22. Does He / She Have Any Other Comments Or Concerns That You Would Like To Bring To Our Attention? _____ Yes No

- 23. Do You Wish To Talk To The Doctor Privately About Any Problem? _____ Yes No

X _____ Date _____
Patient Signature (Parent or Guardian)

Reviewed by: Doctor _____ Date _____