Child Information

Patient Name: (First)_________________________ (M.I.)____ (Last)_____________________________

Sex: M F DOB: ______/_____/_____ Name of School: _____________________________

Home Address:____ City:_____________________________

Home Phone Number: (___) _____-____________ Best Contact Number:(___) _____-____________

Parent Information

Father's Name: (First) ____________ (M.I.) ____ (Last) _____________ Date of Birth: ____/____/___

Employer: ________________________________ Occupation: __________________________________

Business Address: __________________________ City: ______________ State ____ Zip code _______

Work Phone Number: (___) _____-___________ Ext. ______________

Mother's Name: (First) ___________ (M.I.) ____ (Last) _____________ Date of Birth: ____/____/____

Employer: _______________________________ Occupation: ___________________________________

Business Address: __________________________ City: ______________ State ____ Zip code _______

Work Phone Number: (___) _____-___________ Ext. _______________

Emergency Contact: ____ Phone # (___) _____-________

Person responsible for account: ____

Whom may we thank for referring you? ____

Dental Health

Reason for your visit: _______________________ Last teeth cleaning: __________________________

What is your *primary* concern that you wish us to address first? _________________________________

Have you ever had any problems with previous dental treatment? Yes No

If yes, please explain here: ____

Are your teeth sensitive? Yes No

Do your gums feel tender or swollen? Yes No

How often do you brush your teeth? ____________ How often do you floss? ___________

Do you have pain with any of the following? Chewing hot liquids cold liquids sweets none

Are you aware of grinding or clenching your teeth? Yes No

Medical History

General health: Excellent Good Fair Poo r

Name of physician: ____________________________ Telephone Number: ________________________

Physician's address: ____

Have you ever been hospitalized? Yes No If yes, please list reason:______________________

Are you allergic to any medications? Yes No If yes, please list here:________________________

Are you taking any medications? Yes No If yes, please list current medications below:

____

____

Do you smoke? Yes No If yes, how many cigarettes per day?_________________________

Females only:

Are you pregnant? Yes No If yes, when is the due date?________________________________

Are you taking any oral contraceptives? Yes No

Have you ever had any of the following?

Allergy (Hay Fever)	Yes	No	Hepatitis	Yes	No
Sinus or Ear Trouble	Yes	No	Blood Disorder (Anemia, Leukemia)	Yes	No
Respiratory Condition	Yes	No	Excessive Bleeding	Yes	No
Diabetes	Yes	No	Severe or Frequent Headaches	Yes	No
Epilepsy	Yes	No	Abnormal High/Low Blood Pressure	Yes	No
Kidney Disorder or Disease	Yes	No	Thyroid Condition (Hyper/Hypo)	Yes	No
Skin Problem or Disease	Yes	No	Parkinson's Disease	Yes	No
Nervous Disorder, Psychiatric Care	Yes	No	Eye Disease (Glaucoma, Cataract)	Yes	No
Ulcer	Yes	No	Retinal Eye Surgery	Yes	No
Cancer, Tumors, Malignancies	Yes	No	Heart Disease/Condition	Yes	No
X-ray, Radium or Cobalt Treatment	Yes	No	Rheumatic Fever	Yes	No
Herpes, Cold sores, Fever blisters	Yes	No	Scarlet Fever	Yes	No
AIDS or HIV exposure	Yes	No	Heart Murmur	Yes	No
Stroke	Yes	No	Transplants	Yes	No
Arthritis	Yes	No	Artificial Implants (Pacemakers, etc.)	Yes	No

If you have answered "yes" to any of the above, please explain here:

____

____

What are your hobbies? Special interests?

____

____

Signature____ Date______________

If patient is less than 18 years old, parent or legal guardian must sign above.