PATIENT INFORMATION FORM/CHILD Date of Exam_____

Welcome to our office! Please assist us by completing the following questions:

Patient's Name_____Nickname_____Age____Birthdate_____Gender___

Home address _____City_____Zip_____Phone_____

School/Grade_____Primary contact cell #_____Email address_____

Appointment reminder preference (circle one): Text E-mail Phone

List sports & hobbies_____Physician_____

Patient's Dentist_____Who suggested our office? _____

Names and ages of other children in family _____

Other family members treated by this office_____

Marital status of **parents** (circle one) Single Married Separated Divorced Remarried Widowed

Mother's Name_____Soc. Sec #_____

Employed by_____Occupation_____Cell Phone_____

Father's Name_____Soc.Sec. #_____

Employed by_____Occupation_____Cell Phone_____

Step Parent's Name_____Soc. Sec #_____

Employed by_____Occupation_____Cell Phone_____

Patient lives with (circle one): Mom Dad Both Is patient adopted? Yes □ No □

Persons responsible for account_____Relationship_____Phone_____

Address_____City_____Zip_____Email address_____

Insurance: □ Orthodontic □ Dental only □ No Insurance Insured's Name_____Birthdate_____

Insurance Co._____Phone #_____ID#/Group# _____

MEDICAL HISTORY

Has the patient ever had an illness related to any of the following?

	Yes	No		Yes	No		Yes	No
Heart trouble	__	__	Epilepsy	__	__	Diabetes	__	__
Blood pressure	__	__	Asthma	__	__	Arthritis of any kind	__	__
Rheumatic fever	__	__	Kidneys	__	__	Positive HIV Virus (AIDS)	__	__
Prolonged bleeding	__	__	Thyroid	__	__	Neurologic disorders	__	__
Anemia	__	__	Bone Disorders	__	__	Fainting/Dizziness	__	__
Liver (Hepatitis)	__	__						

Is the patient presently in good health? _____

Is there any medical problem (or history of) that we should be aware of? _____

List any drugs/medications now being taken. Give reason_____

List any allergies, drug sensitivities, or congenital abnormalities_____

DENTAL HISTORY (circle one)

Have there been any injuries to the face, mouth or teeth? **YES NO** explain _____

Has the patient ever sucked a thumb or finger? **YES NO** until what age?_____

Is there clicking or discomfort in the patients jaw joints? **YES NO**_____

Does the patient suffer from headaches in the morning, noon, or evening? **YES NO** explain_____

When did the patient last see his/her dentist?_____Were X-rays taken?_____

What are your primary concerns?_____

I authorize the dentist to release my information including the diagnosis and the records if any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I understand my credit information may be obtained. I authorize the dental staff to perform any necessary dental services that my child may need.

_____

Parent's Signature **Date**