PATIENT INFORMATION

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments, or fees, please feel free to ask.

In order to safeguard your health, it is important that you answer the following questions. Please remember that the answers to these questions are held in strict confidence.

CHILD'S BIOGRAPHICAL AND SOCIAL HISTORY (Please print all information clearly)

Child's Full Name _____ Date _____
Last First Middle

Child's Nickname _____ Sex _____ Birthdate _____ Birthplace _____

Brothers/Sisters _____ Hobbies _____ Pets _____ Grade/School _____

Father's Name _____ Phone ( )

Address _____
Street City State Zip

Mother's Name _____ Phone ( )

Address _____
Street City State Zip

Do both parents live together? ____Yes ____No If not, with whom does the child live? _____

Father's Occupation/Employer _____

Address _____ Phone ( )
Street City State Zip

Mother's Occupation/Employer _____

Address _____ Phone ( )
Street City State Zip

If you do not have a phone, list a number where you can be reached _____

Dental Insurance ____No ____Yes

CHILD'S DENTAL AND MEDICAL HISTORY

Is this your child's first visit to the dentist? ____No ____Yes

Is your child on a bottle? ____No ____Yes

Does your child drink fluoridated water? ____No ____Yes ____Do not know

Is your child taking fluoride tablets/drops? ____No ____Yes

How often are your child's teeth brushed? _____ By whom? _____

What type of toothpaste does your child use? _____

Does your child suck his thumb, finger or lip? ____No ____Yes (Which _____)

Has your child had problems with previous dental treatment? ____No ____Yes (What was the problem?)

_____

Does your child have a dental condition about which you are especially concerned? ____No ____Yes

(If yes, what is the condition?) _____

Indicate whether your child presently has or has previously had any of the following conditions:

NO	YES		NO	YES		NO	YES	
____	____	Adrenal disorders	____	____	Ear disorders	____	____	Lung disease
____	____	Anemia	____	____	Eye Disorders	____	____	Mental retardation
____	____	Asthma	____	____	Fainting	____	____	Muscle disorder
____	____	Bleeding tendency	____	____	Heart condition	____	____	Nose/throat disorder
____	____	Blood disease	____	____	Hemophilia	____	____	Prolonged illness
____	____	Bone disorder	____	____	Hepatitis	____	____	Rheumatic fever
____	____	Brain disorder	____	____	High blood pressure	____	____	Skin disease
____	____	Convulsions	____	____	Hyperactivity	____	____	Speech problem
____	____	Diabetes	____	____	Jaundice	____	____	Stomach problem
____	____	Epilepsy	____	____	Liver disease	____	____	Tumors

Is your child taking any medicine? ____No ____Yes (What _____)

Is your child allergic to any medicine or food? ____No ____Yes (What _____)

Has your child ever been hospitalized ____No ____Yes (Explain) _____

_____

Child's Physician _____
Name Address

I certify the above information is correct to the best of my knowledge. I hereby consent to such examinations, x-rays, and diagnostic procedures and tests you may prescribe.

Signature of parent or guardian _____ Date _____