

Date _____

Confidential Responsible Party Information

A B C

Name _____ Marital Status _____
Last First Middle

Residence _____ Own Rent
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____ Cell Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Confidential Patient Information

Patient's Name _____ Birthdate _____
Last First Middle

Address _____ Email _____
Street City State Zip

Home Phone _____ Cell Phone _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

Insurance Information

Policy Holder's Name _____ Member ID# or Soc.Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No Yes If yes:

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

welcome

PATIENT NUMBER

Patient's Name _____

Last

First

Initial

Nickname

Date of Birth

Parent's Guardian's Name _____

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist?YES NO
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? . . .YES NO
4. Does your child eat between meals?YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum?YES NO
6. When does your child brush his/her teeth?
 Upon arising After eating any food Right after meals Before going to bed
7. How does your child receive Fluoride?
 Community water level ____ ppm Well water level ____ ppm
 Fluoride drops or tablets Fluoride rinse or gel
8. Have any cavities been noted in the past?YES NO
9. Were any teeth (baby or permanent) removed by extraction?YES NO
Was it suggested that the space be maintainedYES NO
Was an appliance placedYES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc?YES NO
If so describe _____
11. Has your child had any problem with dental treatment in the past?YES NO
12. Has anyone in the family, including parents, had orthodontics?YES NO
13. Has your child ever received a local anesthetic?YES NO
14. Has your child ever had occlusal sealants?YES NO
15. Does your child think there is anything wrong with his/her teeth?YES NO

MEDICAL HISTORY

1. Does your child have a health problem?YES NO
2. Is your child under care of physician?YES NO
If yes, since when and why? _____
Phone _____
3. Name of physician _____
4. Is your child receiving any medication?YES NO
What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs?YES NO
6. Is your child allergic to or sensitive to any metals or latex?YES NO
7. Does your child have other allergies?YES NO
8. Has your child had any serious illness?YES NO
When _____ What _____
9. Has your child ever had surgery?YES NO
10. Does your child have a heart murmur?YES NO
11. Is surgery contemplated?YES NO
12. Does your child experience severe or prolonged bleeding?YES NO
13. Does your child have AIDS or has he/she tested HIV positive?YES NO
14. Has your child tested positive for hepatitis?YES NO
15. Is your child subject to nervous disorders?YES NO
 Fainting? Seizures? Dizziness? Behavioral/Learning problems?
16. Does your child have frequent headaches?YES NO
17. Has your child had history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

CHILD DENTAL MEDICAL HISTORY