



Patient Name: \_\_\_\_\_

**Medical History**

Has your child ever had or been exposed to any of the following::

- |              |     |    |
|--------------|-----|----|
| HIV          | yes | No |
| Hepatitis C  | Yes | No |
| Hepatitis B  | Yes | No |
| Tuberculosis | Yes | No |

Has your child had or have a history of the following?

- |                     |            |    |
|---------------------|------------|----|
| Heart Murmur        | <b>Yes</b> | No |
| Rheumatic Fever     | <b>Yes</b> | No |
| Heart Condition     | <b>Yes</b> | No |
| Asthma              | <b>Yes</b> | No |
| Abnormal Bleeding   | <b>Yes</b> | No |
| Blood Disorder      | <b>Yes</b> | No |
| HIV/Aids            | <b>Yes</b> | No |
| Epilepsy            | <b>Yes</b> | No |
| Joint Replacement   | <b>Yes</b> | No |
| Diabetes            | <b>Yes</b> | No |
| Radiation Treatment | <b>Yes</b> | No |
| Physical Disability | <b>Yes</b> | No |
| Mental Disability   | <b>Yes</b> | No |
| ADHD/Hyperactivity  | <b>Yes</b> | No |
| Other               | <b>Yes</b> | No |

Please Explain \_\_\_\_\_

**DENTAL HISTORY**

- |                     |            |    |
|---------------------|------------|----|
| Oral Habits         | <b>Yes</b> | No |
| Orthodontics        | <b>Yes</b> | No |
| Frequent tooth pain | <b>Yes</b> | No |
| Peridontal disease  | <b>Yes</b> | No |
| Grinding/Clenching  | <b>Yes</b> | No |
| Good Oral Health    | <b>Yes</b> | No |

**HOME CARE**

- |                      |            |    |
|----------------------|------------|----|
| Fluoride supplements | <b>Yes</b> | No |
| Brushes Teeth daily  | <b>Yes</b> | No |

**LAST DENTAL VISIT** \_\_\_\_\_

**MEDICATION**

Is your child now taking or has your child ever taken:

- |                      |            |    |
|----------------------|------------|----|
| Cortisone (steroids) | <b>Yes</b> | No |
| Inhaler              | <b>Yes</b> | No |
| Chemotherapy         | <b>Yes</b> | No |

**ALLERGIES**

- |                  |            |    |
|------------------|------------|----|
| Local Anesthetic | <b>Yes</b> | No |
| Penicillin/Sulfa | <b>Yes</b> | No |
| Latex            | <b>Yes</b> | No |
| Other Allergies  | <b>Yes</b> | No |

Please explain any yes \_\_\_\_\_

Name and number of current Physician and last PHYSICAL

List Any Hospitalization/Surgeries \_\_\_\_\_

Other Explain \_\_\_\_\_

List Any Medication \_\_\_\_\_

List Any Allergies \_\_\_\_\_

Other \_\_\_\_\_

TO THE BEST OF MY KNOWLEDGE ALL ANSWERS AND CORRECT. IF THERE ARE ANY CHANGES TO MY CHILDS HEALTH OR MEDICAL HISTORY, I WILL IMMEDIATELY INFORM THIS OFFICE OF SUCH CHANGES.

\_\_\_\_\_  
PARENT/GUARDIAN

\_\_\_\_\_  
DATE



### Patient Information

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex Male Female  
Cell Phone: \_\_\_\_\_ email address: \_\_\_\_\_@\_\_\_\_\_

Please initial below if you would NOT like to receive appointment reminders via email and/or text:  
\_\_\_\_\_ I would **NOT** like to receive email and/or text appointment reminders

### Parent/Guardian Information

<u>Father</u>	<u>Mother</u>
Full name _____	Full name _____
Date of Birth _____	Date of Birth _____
Home address _____	Home address _____
State _____ Zip _____	State _____ Zip _____
Employer _____	Employer _____
SS# _____ DL# _____	SS# _____ DL# _____
Name of person financially Responsible for payment _____	
Emergency Contact _____	

### Insurance

*(Insurance Information must be completed in full if you would like us to bill for services)*

<u>Primary</u>	<u>Secondary</u>
Policy Holder _____	Policy Holder _____
Insurance Company _____	Insurance Company _____
Address _____	Address _____
City _____ St _____ Zip _____	City _____ St _____ Zip _____
Phone Number _____	Phone Number _____
Policy Number _____	Policy Number _____

How did you hear about our office?

- Google/Internet**
- Friend or Relative (please list who, so that we may thank them!)** \_\_\_\_\_
- Phonebook**
- Mailer**
- Other:** \_\_\_\_\_

All of the above information is true and correct to the best of my knowledge. If there are any changes to my child's or my information I will inform this office immediately.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date