

Date \_\_\_\_\_

**PATIENT INFORMATION** *Answers to all Questions are for Office Use and Strictly Confidential*

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Sex: M F Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS Number \_\_\_\_\_

Previous General Dentist (Name, Address & Phone Number) \_\_\_\_\_

Reason For Changing Dentist \_\_\_\_\_

**PARENTS INFORMATION**

Fathers Name \_\_\_\_\_ SS Number \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Cell Phone \_\_\_\_\_ Occupation \_\_\_\_\_ Employed By \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Mothers Name \_\_\_\_\_ SS Number \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Cell Phone \_\_\_\_\_ Occupation \_\_\_\_\_ Employed By \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Nearest Friend or Relative (Name & Phone Number) \_\_\_\_\_

How Did You Here About Our Office  Friends  Family  Website  Phone Book  Location  Other \_\_\_\_\_

**INSURANCE INFORMATION**

Who Is Responsible For Account \_\_\_\_\_

Dental Insurance Company \_\_\_\_\_ Subscriber \_\_\_\_\_

Insurance ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

**MEDICAL HISTORY**

1. Medical Doctor (Name, Address & Phone Number) \_\_\_\_\_

2. Is Your Child In Good Health? Yes No Explain: \_\_\_\_\_

3. Has He / She Had A Physical Exam In The Last Year? Yes No Date: \_\_\_\_\_

4. Is Your Child Now Under Medical Care? Yes No Why: \_\_\_\_\_

5. Is He / She Taking Any Medications, Supplements or Drugs? Yes No What: \_\_\_\_\_

6. Is He / She Allergic To Any Medications or Substances? Yes No What: \_\_\_\_\_

7. Is The Patient Pregnant? (Adolescent Woman) Yes No Due Date: \_\_\_\_\_

**MARK AN X IN THE BOX IF YOU HAVE HAD ANY OF THE FOLLOWING**

- |   |   |  |  |   |  |
|---|---|--|--|---|--|
| <input type="checkbox"/> Aids / HIV             | <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Excessive Thirst      | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Lung Disease       | <input type="checkbox"/> Sinus Trouble         |
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Cerebral Palsy           | <input type="checkbox"/> Fainting Of Dizziness | <input type="checkbox"/> Hepatitis A (Infect.) | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Snoring / Sleep Apnea |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Chemotherapy / Radiation | <input type="checkbox"/> Fever Blisters        | <input type="checkbox"/> Hepatitis B (Serum)   | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Thyroid Disease       |
| <input type="checkbox"/> Arthritis / Gout       | <input type="checkbox"/> Cold Sores               | <input type="checkbox"/> Frequent Cough        | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Pain In Jaw Joints | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Congenital Heart Lesion  | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Psychiatric Care   | <input type="checkbox"/> Ulcers                |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Cortisone Medicine       | <input type="checkbox"/> Hearing Disability    | <input type="checkbox"/> Hives or Skin Rash    | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Venereal Disease      |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism         | <input type="checkbox"/> X-ray Or Cobalt Tmt.  |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Drug Addiction           | <input type="checkbox"/> Heart Surgery         | <input type="checkbox"/> Kidney Trouble        | <input type="checkbox"/> Scarlet Fever      | <input type="checkbox"/> Yellow Jaundice       |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Epilepsy Or Seizures     | <input type="checkbox"/> Heart Trouble         | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sickle Cell Anemia |  |

8. Have You Ever Had Any Other Serious Illness Or Condition Not Marked Above? Describe In Detail: \_\_\_\_\_ Yes No

**DENTAL HISTORY**

1. Does Your Child Have A Specific Dental Problem? Describe: \_\_\_\_\_ Yes No  
\_\_\_\_\_
2. Does Your Child Have Dental Examinations On A Routine Basis? Date of Last Visit: \_\_\_\_\_ Yes No  
Last X-Rays: \_\_\_\_\_ Last Fluoride Tx: \_\_\_\_\_ Last Cleaning: \_\_\_\_\_
3. Would You Describe Their Present Dental Health As Good? Comments: \_\_\_\_\_ Yes No  
\_\_\_\_\_
4. Has He / She Been Treated For Any Gum Diseases (Gingivitis, Periodontitis, Trench Mouth, Pyorrhea)? \_\_\_\_\_ Yes No
5. How Often Does He / She Brush? \_\_\_\_\_ Floss? \_\_\_\_\_ Use Mouth Rinses? \_\_\_\_\_ Yes No
6. Does He / She Feel Nervous About Having Dental Treatment? \_\_\_\_\_ Yes No
7. Has He / She Ever Had A Bad Experience In A Dental Office? Describe: \_\_\_\_\_  
\_\_\_\_\_
8. Does He / She Ever Brux Or Grind Your Teeth? Discuss: \_\_\_\_\_ Yes No
9. Has He / She Ever Had Orthodontic Treatment (Tooth Straightening)? \_\_\_\_\_ Yes No
10. Does He / She Ever Have Clicking, Popping Or Discomfort In The Jaw Joints (TMJ)? \_\_\_\_\_ Yes No  
Please Discuss: \_\_\_\_\_
11. Has He / She Had A Root Canal Or Pulpotomy Treatment? \_\_\_\_\_ Yes No
12. Has He / She Ever Lost A Tooth Due To An Accident Or Decay? \_\_\_\_\_ Yes No
13. Has He / She Often Had Toothaches? \_\_\_\_\_ Yes No
14. Has He / She Had Frequent Sores In His / Her Mouth? \_\_\_\_\_ Yes No
15. Has He / She Had Any Injuries To His / Her Mouth Or Jaw? \_\_\_\_\_ Yes No
16. Has He / She Ever Had A Thumb Sucking Habit Or Used A Pacifier? \_\_\_\_\_ Yes No
17. Does He / She Use Tobacco? What Type? \_\_\_\_\_ Yes No
18. Does He / She Frequently Snack On Sweets, Chew Gum Or Drink Pop? \_\_\_\_\_ Yes No
19. What Has Been Used For Comfort In Previous Dental Treatment?  Local Anesthetic  N<sub>2</sub>O Gas  Neither Yes No
20. Has He / She Had A Reaction To Dental Anesthetic? \_\_\_\_\_ Yes No
21. Has He / She Been Told They Need To Be Pre-Medicated For Dental Treatment? \_\_\_\_\_
22. Does He / She Have Any Other Comments Or Concerns That You Would Like To Bring To Our Attention? \_\_\_\_\_ Yes No  
\_\_\_\_\_
23. Do You Wish To Talk To The Doctor Privately About Any Problem? \_\_\_\_\_ Yes No

X \_\_\_\_\_ Date \_\_\_\_\_  
Patient Signature (Parent or Guardian)

Reviewed by: Doctor \_\_\_\_\_ Date \_\_\_\_\_