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& Associates
A PROFESSIONAL DENTAL CORPORATION

THE FOLLOWING INFORMATION IS NECESSARY FOR US TO UNDERSTAND AND ADEQUATELY TREAT YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

***Today's Date*: _____**

I. Patient Information

***Language preferred**: English or list other:_____*
(circle)

Name (last) _____ (first) _____ (middle) _____
Sex: Male or Female Name child prefers to be called _____
Address (street)_____ (city)_____ (state)_____ (zip) _____
Phone # _____ Birthday _____ Social Security # _____
Names and ages of other children in family _____

Whom may we thank for telling you about our office _____

II. Family Information

Father _____ Mother _____
Address _____ Address _____
_____ _____
Hm Ph# _____ Hm Ph# _____
Cell # _____ Cell # _____
Employer_____ Employer_____
Work Phone #_____ Work Phone #_____
Social Security #_____ Social Security #_____
Date of birth_____ Date of birth _____
Email Address_____ Email Address_____
Marital Status: Married, Single, Widowed, Divorced (circle one) Marital Status: Married, Single, Widowed, Divorced (circle one)

III. Emergency Information

Name of nearest relative not living with you_____
Address_____ Phone #_____ Relationship_____

Name of nearest friend not living with you_____
Address_____ Phone #_____ Relationship_____

IV. Responsible Party for Payment of Account *(if different from parent info above)*

Name (last) _____ (first) _____ (middle) _____
Residence (street) _____ (city) _____ (state) _____ (zip) _____
Mailing Address (street) _____ (city) _____ (state) _____ (zip) _____
# of years at this address _____ Home Phone # _____ Cell#_____
Social Security # _____ **Birthday** _____ Relationship to Patient _____
Employer _____ Position _____Business Ph# _____

Spouses Name (last) _____ (first) _____ (middle) _____
Social Security #_____ **Birthday** _____ Relationship to Patient_____
Employer _____ Position _____ Business Ph#_____

V. Payment options for Professional Fees

1. Pre-payment of dental care to be rendered prior to appointment
2. Cash / check
3. Visa / Master Card / Discover / American Express
4. Care credit
5. Medicaid / State Insurance
6. Dental Insurance Company ***(we will need copy of insurance card to file insurance claims)***

   Insured's Name _____

   Insured's SS#_____

   Insured's date of birth_____

   Group # _____ **(if not listed on insurance card)**

VI. Reason for Today's Appointment

Check up & Cleaning____ Exam Only____ Evaluate Crowding___ Toothache____ 2nd Opinion____

Other_____

VII. Dental History

Is this the child's first visit to a dentist? Yes or No

Date of child's last dental visit?_____ Dentist? _____

Do you brush your child's teeth? _____ Do you floss your child's teeth?_____

Are you currently breastfeeding or bottle feeding the child? _____

Do you have fluoridated water in your home? Yes or No (circle one)

Father's Dentist? _____ Mother's Dentist? _____

Have there been any injuries to the teeth, such as falls, blows, chips, etc.? _____

Please Explain: _____

VIII. Medical History

Child's Physician _____ Phone # _____

** Does child have any history of pre-mature birth? Yes or No

Was child ever in NICU? Please explain: _____

** Has child ever been hospitalized? No or Yes Please explain: _____

_____

Has your child ever had any of the following conditions? (check ALL that apply)

- ☐ Seasonal Allergies
- ☐ Allergies to any foods- please list _____
- ☐ Allergy to Latex
- ☐ Aspirin Allergy
- ☐ Anemia
- ☐ AIDS/HIV
- ☐ Anxiety or Depression
- ☐ Bleeding disorders
- ☐ Blood Disease
- ☐ Cancer-- please list:_____
- ☐ Crohn's Disease
- ☐ Diabetes: Type ____
- ☐ Dizziness / Fainting
- ☐ Emotional Disturbance
- ☐ Excessive Bleeding
- ☐ Eczema
- ☐ Heart Murmur _____
- ☐ Head Injury
- ☐ Hepatitis
- ☐ Hay Fever
- ☐ High Blood Pressure
- ☐ History of Abuse
- ☐ Heart Disease / Abnormalities
- ☐ Joint Replacement or Implant
- ☐ Kidney Disease / Problems
- ☐ Liver Disease / Problems
- ☐ Low Blood Pressure
- ☐ Leukemia
- ☐ Mitral Valve Prolapse
- ☐ History of MRSA? Last episode: _____
- ☐ Mental Impairment/Condition _____
- ☐ Psychiatric Care
- ☐ History of RSV? Last episode: _____
- ☐ Radiation Treatment / Chemotherapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus problems
- ☐ Sickle Cell Anemia
- ☐ Stomach Troubles / Ulcer
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Autism _____
- ☐ ADHD – Medication taken: _____
- ☐ ADD – Medication taken: _____
- ☐ **Other condition**: _____

☐ **Asthma** -- How often do attacks occur? _____ Last attack?_____

<u> History of breathing treatments?</u>** Yes No Last treatment given:_____

What medicines that are taken? _____ Name of treating Doctor: _____

<u>Reason for treatment</u>: _____

☐ **Epilepsy** ☐ **Seizures**--What type of seizure? _____ How often do they occur? _____
How long do they last? _____ When was last seizure? _____

Is the child allergic to or have had any reactions to the following? ***please circle <u>all</u> that apply***

Local Anesthetics (Novocaine, Lidocaine, Codeine) / Penicillin, Amoxicillin or other antibiotic / Sulfa Drugs

Sedatives / Barbiturates / Aspirin / Any metals (nickel, mercury, etc) / Latex Rubber / Iodine / Red Dye

Other (please list) _____ *or No Known Drug Allergy*

Has your child ever been under general anesthesia? Yes or No

List surgeries and dates _____

_____

Are your child's immunizations/vaccinations up to date? Yes or No

Is your child under medical care at the present time for any other condition? Yes or No

Please advise: _____

Is your child currently taking any medications? Yes or No

Please List: _____ _____ _____

_____ _____ _____

Is there any other information about your child that you think would be of value to us for providing his/her dental care? _____

Information Name (print) _____ Date _____

provided by: (signature) _____ Relation to patient_____