

Patient Information

Date: _____ Chart # _____

Patient's Name: _____

Child's Nickname: _____

Last _____ First _____ Middle Initial ____ Birthdate _____ Age ____ Sex: M F

It is important that I know about your Child's Medical and Dental History. These facts have a direct bearing on his/her Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Dental History		Yes	No	Medical History		Yes	No
Is your child's present dental health good?				Date of your child's last physical exam: _____			
If no explain:				Is your child under a physician's care now?			
Is this your child's first dental visit?				If yes, for what?			
Does your child use the bottle, pacifier, suck thumb/finger?				List any medications and dosages your child is currently taking?			
If yes explain:							
Does your child show age-appropriate behavior?				Any other medical information that we should know?			
If no explain:				If yes what?			
Anything special you would like us to know about your child?				Does your child have or ever had any of the following?			
If yes explain:				AIDS/HIV Positive	Yes No	Hemophilia (abnrl bleeding)	Yes No
Has your child used fluoridated vitamins?				Anaphylaxis	Yes No	Herpes	Yes No
Has your child used fluoridated toothpaste?				Anemia	Yes No	Hepatitis	Yes No
Does your child drink tap water or bottled water? Circle which one				Arthritis (Rheumatism)	Yes No	High blood pressure	Yes No
Has your child worn braces (orthodontics)?				Artificial heart valves	Yes No	Jaw pain	Yes No
Are you interested in braces for your child?				Artificial joints	Yes No	Kidney disease/malfunction	Yes No
Does your child use dental floss regularly?				Asthma	Yes No	Liver disease	Yes No
Does your child have any dental problems now?				Atopy (Allergy Prone)	Yes No	Mitral Valve Prolapse	Yes No
If yes tell us what:				Back problems	Yes No	Nervousness	Yes No
Does your child have allergies to, if yes list what				Blood disease	Yes No	Pacemaker	Yes No
Drugs:				Cancer	Yes No	Psychiatric care	Yes No
Foods:				Chemical dependency	Yes No	Rapid weight gain/loss	Yes No
Latex or rubber products such as balloons?				Chemotherapy	Yes No	Radiation treatment	Yes No
About Your Child: Please list any sports your child participates in: What hobbies does your child enjoy/participate in: What does your child like best about school: Favorite TV show, movie, and reading materials:				Circulatory problems	Yes No	Respiratory disease	Yes No
				Cortisone treatments	Yes No	Rheumatic/scarlet fever	Yes No
				Cough (persistent)	Yes No	Shortness of breath	Yes No
				Cough up blood	Yes No	Skin rash	Yes No
				Diabetes	Yes No	Stroke	Yes No
				Epilepsy	Yes No	Surgical implant	Yes No
				Fainting	Yes No	What type of implant?	
				Food allergies	Yes No	Swelling of feet/ankles	Yes No
				Glaucoma	Yes No	Thyroid disease	Yes No
				Headaches	Yes No	Tobacco habit	Yes No
		Heart attack	Yes No	Venereal disease	Yes No		
		Heart murmur	Yes No	Ulcerative/Colitis	Yes No		
		Heart Surgery	Yes No	Tuberculosis	Yes No		
		Heart problems	Yes No				

Please list what heart problems:

Material allergies (latex, metals, chemicals.)	Yes No
If yes list what allergies:	

Consent:

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the doctor and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the doctor. Any payments received by the doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that, where appropriate, credit reports may be obtained. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient/Guardian Signature _____ Dentist Signature _____