FAMILY AND CHILDREN'S dentistry
"With A Lott Of Love"

Date ______________

EMAIL ADDRESS ______________ Chart No. ______________

PATIENT'S NAME ______________ NICKNAME ______________

DATE OF BIRTH ______________ AGE ________ SEX ________ GRADE ________ SCHOOL ______________

PATIENT'S ADDRESS ______________ APT. # ________ CITY ______________ STATE ________ ZIP ________

FATHER'S FULL NAME ______________ Living ❑ Deceased ❑ SOCIAL SECURITY # ______________

FATHER EMPLOYED BY ______________ OCCUPATION ______________ HOW LONG ________

FATHER'S HOME PHONE ______________ BUSINESS PHONE ______________

MOTHER'S FULL NAME ______________ Living ❑ Deceased ❑ SOCIAL SECURITY # ______________

MOTHER EMPLOYED BY ______________ OCCUPATION ______________ HOW LONG ________

MOTHER'S HOME PHONE ______________ BUSINESS PHONE ______________

MARITAL STATUS OF PARENTS: Married [ ] Separated [ ] Divorced [ ] Other [ ] ______________

GUARDIAN or INSURED PARENT ______________ DATE OF BIRTH ______________ SOCIAL SECURITY # ______________

NO. OF CHILDREN ________ AGES ______________

NAME AND PHONE NUMBER OF NEAREST RELATIVE, NOT AT THE ABOVE ADDRESS ______________

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? ______________

IS THE PATIENT COVERED BY DENTAL INSURANCE? ______________ MEDICAID? ______________

NAME OF CARRIER ______________

Payment of Professional Fees:

The policy of payment for dental services in this office will be cash, check, Visa, Mastercard or American Express. Portions of the bill not covered by dental insurance are the responsibility of the parent or guardian of the child and are due at the conclusion of each visit. Medicaid recipients must present their card at the beginning of each visit. I understand a reservation fee is due for sedation appointments.

Medical History

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease			Sinusitis, Hay Fever			Special Diets			Blood Disease		
Asthma			Tuberculosis			Rheumatic Fever			Cancer		
Chronic Cough			Epilepsy			Heart Murmur			Cleft Lip/Palate		
High Blood Pressure			Nervous Disorder			Scarlet Fever			Colic		
Kidney Disease			Thyroid Disorder			Frequent Colds			Liver Disease		
Stomach Disorder			Hyperactivity			Immune Deficiency			Hepatitis		
Diabetes			Bleeding Disorder			Shortness of Breath			Anemia		
HIV/AIDS											

Does your child have a mental handicap? ________ Does your child have a physical handicap? ________

Is the child or adolescent taking any medicine at this time? Yes ❑ No ❑

Check what kind: ❑ Antibiotics ❑ Anticoagulants ❑ Tranquilizers ❑ Anticonvulsants ❑ Cortisone ❑ Others ______________

Has the child or adolescent had any unfavorable reaction to the following drugs? Please check which ones: Yes ❑ No ❑

❑ Penicillin ❑ Local Anesthetics ❑ Barbiturates ❑ Sulfa drugs ❑ General Anesthetics ❑ Aspirin ❑ Other drugs or medications

Does the child or adolescent have any history of allergies: Yes ❑ No ❑

If yes, to what? ______________

Describe the reaction and when it happened. Was this recent? ______________

Name of patient's physician ______________ Date of Last Examination ______________

DENTAL

Please check the reason(s) for seeking dental care: ❑ Routine Checkup ❑ Appearance of teeth ❑ Accident to teeth ❑ Toothache

❑ Swelling of face ❑ Bleeding around the teeth ❑ Crowding ❑ Other (specify) ______________

How do you feel your child will react to the dentist? ______________ Has your child ever visited a dentist before? ______________

Does your child relate well to children of the same age? ________ Do you feel your child will need special care? ______________

Does your child relate well to adults? ________ Do you feel your child will need braces? ______________

Date ______________ Signature ______________

Doctor's Summary ______________

____

____

Dentist or HYG Signature ______________ 6 mos Signature ______________