"A Better Life Starts With A Beautiful Smile"

Patient's Name _____ Nickname _____
DOB: ___/____/____ Sex: Female/Male Referred By: _____
Parent's/Guardian's Name _____ Relationship to Patient _____
Home Phone (_____) _____-_____ Work Phone (_____) _____-_____
Parent's SSN:_____Email:_____
Address _____ Apt # _____ City _____ Zip Code_____
Physician's Name _____ Physician's Phone (_____) _____-_____

Indicate which of the following conditions your child has now or has had. Mark each answer individually.

☐ Anemia	☐ Cerebral Palsy	☐ Growth Problems	☐ Mononucleosis	☐ Venereal Disease
☐ Arthritis	☐ Chicken Pox	☐ Hearing	☐ Mumps	☐ Other
☐ Asthma	☐ Chronic Sinusitis	☐ Heart	☐ Pregnancy (teens)	_____
☐ Bladder	☐ Diabetes	☐ Hepatitis	☐ Rheumatic Fever	
☐ Bleeding Disorders	☐ Ear Aches	☐ HIV/AIDS	☐ Sickle Cell	
☐ Bones/Joints	☐ Epilepsy/ Seizures	☐ Latex Allergy	☐ Thyroid	
☐ Cancer	☐ Fainting	☐ Measles	☐ Tuberculosis	

For the following questions, circle yes or no, whichever applies?

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? …. Yes No
   If yes, please list: _____
2. Is your child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? …….. Yes No
   If yes, please explain: _____
3. Is the child allergic to anything else, such as certain foods? …… Yes No
   If yes, please explain: _____
4. How would you describe the child's eating habits? _____
5. Has the child ever had a serious illness or been hospitalized? …….. Yes No
   If so, please explain: _____
6. Has the child ever received general anesthetics? ……... Yes No
7. Does the child have any speech difficulties? ……. Yes No
8. Is the child physically, mentally, or emotionally impaired? …….. Yes No
9. Is this the child's first visit to a dentist? ……. Yes No
   If not the first visit, what was the date of the last dentist visit? Date: _____
10. Has the child had any problem with dental treatment in the past? …….. Yes No
    If so, please explain: _____ Yes No
11. Has the child ever had dental radiographs (x-rays) exposed? …….. Yes No
12. Has the child ever suffered any injuries to the mouth, head or teeth? ……. Yes No
13. Has the child had any orthodontic treatment? ……. Yes No
14. How many times are the child's teeth brushed per day? _____ …….. Yes No
    When are the teeth brushed? _____
15. Does child suck his/her thumb, fingers, or pacifier? …… Yes No
16. At what age did the child stop bottle feeding? Age: ____ Breast Feeding? Age: ____ ……...
17. Does child participate in active recreational activities? ……... Yes No
    If so, please explain: _____

Note: Both doctor and patient/parent are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____