

Child's Name _____ Date of Birth _____ Male ___ Female ___ Age ___
Last dental visit _____ Child's previous dentist _____
Purpose of this visit _____
Who may we thank for referring you to our office? _____
Child's School _____

Health History

Child's Physician _____
Is your child under a physician's care now? _____ Reason _____
Is your child taking any medications or drugs? _____ What kind _____ Reason _____
Is your child allergic to any medications? _____ Please list _____
Does your child have allergic reaction to: food ___ animals ___ pollen ___ dust ___ latex ___ other _____
Does your child have any of these habits: finger/thumb sucking ___ pacifier ___ nail biting ___ teeth grinding ___
Lip sucking ___ snoring ___ mouth breathing ___ nursing bottle _____
Has your child had any injuries to teeth, mouth or head? _____ Describe _____
Has your child had a history or difficulty with any of the following:

Yes	No	Yes	No	Yes	No	Yes	No
___ ___	Premature Birth	___ ___	Delayed Development	___ ___	Emotional Problems	___ ___	Nosebleeds
___ ___	Heart	___ ___	Motion sickness	___ ___	Speech Disorder	___ ___	Asthma
___ ___	Seizures	___ ___	Earaches	___ ___	Hearing	___ ___	Liver
___ ___	Immune Disorder	___ ___	Kidney	___ ___	Bone Disorder	___ ___	Allergy to medicine
___ ___	Cerebral Palsy	___ ___	Brain injury	___ ___	Rheumatic Fever	___ ___	Diabetes
___ ___	Fainting or dizziness	___ ___	Bruising	___ ___	Tuberculosis	___ ___	Hepatitis
___ ___	Bladder	___ ___	Anemia	___ ___	Cancer or malignancies		

First names of child's siblings _____

General Information

Father/Parent #1 _____ SSN _____ DOB _____
Address _____ City _____ Zip Code _____
Home Phone _____ Cell Phone _____ Email _____
Relationship to Patient _____ Employer/Occupation _____ Work Phone _____

Mother/Parent #2 _____ SSN _____ DOB _____
Address _____
Home Phone _____ Cell Phone _____ Email _____
Relationship to Patient _____ Employer/Occupation _____ Work Phone _____

Insurance Information

Do you have dental insurance coverage for this child? _____
Name of insured _____ Name of insurance company _____
Group # _____ Address of insurance company _____ Phone # _____
IF YOU HAVE DUAL COVERAGE, PLEASE COMPLETE FOR SECONDARY CARRIER;
Name of insured _____ Name of insurance company _____
Group # _____ Address of insurance company _____ Phone # _____

The permission of parent or guardian is necessary for dental treatment. I give the dentists permission to use such measures as deemed necessary in their professional judgement to render the best dental treatment for my child including the use of anesthetics and medication considered necessary. Parents will be consulted before any treatment is started.

Signature _____ Relationship _____ Date _____