Patient Information

Patient's full Name: _____ Nickname/Preferred Name:_____
DOB: _____ Gender: M/F
Address: _____
City: _____ Zip: _____ **How did you hear about us?**_____

Mother/Guardian's Name:
First Name: _____ Last Name: _____ DOB: _____
SSN# _____***(required)*** Employer:_____
Home/Cell#:_____ Work#:_____
Email:_____

Father/Guardian's Name:
First Name: _____ Last Name: _____ DOB:_____
SSN#:_____Phone: Cell #_____ Work #_____
Email: _____Emplolyer:_____

Insurance:
Dental Insurance Co:_____ Group#_____
ID#_____Subscriber:_____

Emergency Contact: _____**(other than parent)** Relationship:_____
Work # _____ Home/Cell # _____

Dental History
Is this the patient's first visit to a dentist? **Y N**
Has patient been seen by a dentist regularly? **Y N** Last Visit:_____
Dentist Name: _____ Phone:_____ Location:_____
Has the patient had any dental treatment in the past? **Y N**
Type:_____
Has the patient ever had a difficult experience at a dental visit? **Y N** Explain _____
Has patient had any injuries to face/mouth/or teeth? **Y N** Please Explain_____
Has patient ever sucked fingers and or thumb? **Y N** Age habit ended? _____
Does patient have any speech disorders? **Y N** If yes, what? _____
Is patient a mouth breather**? Y N** While awake ☐ While asleep ☐
Does patient have any popping/clicking/or discomfort when opening or closing his/her mouth? **Y N**
Is your drinking water fluoridated? **Y N** Is patient taking fluoride supplement **Y N**
If so what type (e.g. tablets, rinse) Explain_____
How often are teeth brushed? _____ Flossed? _____ By whom?_____

Patient Name_____

Physician_____ Phone#_____

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Patient's current weight: _____ Patient height: _____ Is patient in good health? **Y N**

Is patient under a physician's care? **Y N** If yes for what condition?_____

Does patient need any pre-medication/antibiotic prior to dental treatment? **Y N**

Does patient have any history of major illness? **Y N** If yes when?

_____

Has patient ever been hospitalized? **Y N** If yes, for what?

_____

Is patient taking any medications at this time? **Y N**

If yes please list

medications:_____

Does patient have the following conditions frequently?

☐ Colds	☐ Ear Infections	☐ Sore Throat	☐ Sinus Congestion	☐ Breathing Problems

Please check any of the following conditions for which the patient has been treated:

☐ Aids/HIV	☐ Cerebral Palsy	☐ Hearing Disorder	☐ Nutritional Disorders	☐ Tuberculosis
☐ Arthritis	☐ Diabetes	☐ Heart Disorders	☐ Prolonged Bleeding	
☐ Asthma	☐ Epilepsy/Seizures	☐ Hepatitis	☐ Rheumatic Fever	
☐ Blood Disorders	☐ Endocrine Disorders	☐ Kidney Disease	☐ Speech Disorders	
☐ Bone Disorders	☐ Fainting/Dizziness	☐ Mental Disorders	☐ Tonsillitis	

Other/Explain

_____

Does patient have any allergies or drug sensitivities? **Y N** If yes please list:

_____

Has patient had tonsils and/or adenoids removed? **Y N** If yes when _____

Do you authorize any other adult guardian to accompany your child to their visits on your behalf?

Name:_____ Relationship_____

Name:_____ Relationship_____

Parent/Guardian Name_____Signature_____

Dentist Signature_____ Date_____

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