

**PATIENT INFORMATION FORM**

Please complete and return this form on the first visit. If the space is inadequate, use remark section. Thank you for your cooperation.

**PERSONAL**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Nickname \_\_\_\_\_ Place of Birth \_\_\_\_\_

Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Home Address Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Mother's Employer \_\_\_\_\_

Business Address Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Father's Employer \_\_\_\_\_

Business Address Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Child's Physician \_\_\_\_\_

Address Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Child's Previous Dentist (if applicable) \_\_\_\_\_

Address Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Child's School \_\_\_\_\_ Grade \_\_\_\_\_

Age & Name of Siblings \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

Dental Coverage

Company \_\_\_\_\_

Policy # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Major Medical Coverage

Company \_\_\_\_\_

Policy # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

**DENTAL HEALTH HISTORY**

"x" The main reason for the first visit. Also place a "v" next to problems about which you are concerned.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> First Exam       | <input type="checkbox"/> Cavities               | <input type="checkbox"/> Crowding of Teeth |
| <input type="checkbox"/> Routine Cheek-up | <input type="checkbox"/> Broken Tooth           | <input type="checkbox"/> Thumb Habit       |
| <input type="checkbox"/> Accident         | <input type="checkbox"/> Toothache/Swelling     | <input type="checkbox"/> Other Habits      |
| <input type="checkbox"/> Bleeding Gums    | <input type="checkbox"/> Staining/Discoloration | <input type="checkbox"/> Other Problems    |

Please circle either YES or NO. Please complete all questions.

**Past dental history of your child.**

1. Is this the first visit to a dentist? Yes    No
  
2. If your child has been to a dentist previously,
  - a. When was last visit? Date \_\_\_\_\_
  - b. Have x-rays been taken and when? Date \_\_\_\_\_
  - c. How did your child react and describe his/her temperament \_\_\_\_\_  
\_\_\_\_\_
  
3. How do you think your child will react to dental treatment now? \_\_\_\_\_  
\_\_\_\_\_
  
4. Has your child had Fluoride in any of the following forms?
 

Fluoride tablets or in multi-vitamins	Don't know	Yes	No
Drinking water (community fluoridation)	Don't know	Yes	No
Topical application on teeth: Last Date _____	Don't know	Yes	No
Toothpaste: Brand _____			
  
5. Does your child brush his/her own teeth?  
How frequently and when?    A.M.    P.M.    After Snacks    Before Bed    After Breakfast Yes    No
  
6. Do you brush your child's teeth?  
How frequently and when?    A.M.    P.M.    After Snacks    Before Bed    After Breakfast Yes    No
  
7. Do you floss your child's teeth?  
How frequently and when?    A.M.    P.M.    After Snacks    Before Bed    After Breakfast Yes    No
  
8. Does your child have between meal snacks? Yes    No
  
9. Have your child's teeth ever been injured in an accident? Yes    No  
 When? \_\_\_\_\_  
 Which teeth? \_\_\_\_\_  
 Cause? \_\_\_\_\_  
 Were the teeth treated? Yes    No  
 If so, describe treatment \_\_\_\_\_
  
10. Has your child received any unusual dental or surgical treatment to the mouth? Yes    No  
 If so, what? \_\_\_\_\_
  
11. Does your child have any of the following habits? (Indicate ages when)  
 Bottle to bed at night or nap \_\_\_\_\_  
 What was in bottle? \_\_\_\_\_  
 Use a pacifier? \_\_\_\_\_  
 Thumb or finger sucking \_\_\_\_\_  
 Tongue thrusting \_\_\_\_\_  
 Mouth breathing \_\_\_\_\_  
 Grinds teeth \_\_\_\_\_
  
12. Does your child tend to get frequent headaches? Yes    No  
 How often? \_\_\_\_\_ Duration \_\_\_\_\_  
  
 Does your child tend to get frequent earaches? Yes    No  
 How often? \_\_\_\_\_  
  
 Does your child tend to complain of clicking, popping or crunching noises in his/her ears while chewing? Yes    No

# MEDICAL HISTORY

(Questions asked so hereditary factors may be evaluated)

1. Birth History
- |   |     |    |
|---|-----|----|
| Was this child born premature?  | Yes | No |
| Were there any problems during pregnancy?                               | Yes | No |
| Did you take any medicine during pregnancy?                             | Yes | No |
| Were there any problems with the delivery?                              | Yes | No |
| Did child go home with mother?  | Yes | No |
| Did your child have pneumonia or staph infection during the first year? | Yes | No |
| Is this child adopted?  | Yes | No |

Any other information that might be pertinent? \_\_\_\_\_  
\_\_\_\_\_

2. General Health:
- |   |     |    |
|---|-----|----|
| Is a physician treating your child now for an illness | Yes | No |
| If so, for what reason _____                          |     |    |

Is your child taking any medication at this time?	Yes	No
<u>Drug</u> _____ <u>Dose</u> _____ <u>Frequency</u> _____ <u>Reason</u> _____		

Has your child taken any unusual medications in the past?	Yes	No
If so, what? _____		

- |  |     |    |
|--|-----|----|
| Has your child shown any allergies or unusual reactions? | Yes | No |
| a. Medications or drugs _____                            |     |    |
| b. Foods _____   |     |    |
| c. Other _____   |     |    |

Has your child had any of the following immunizations:

_____ DPT: Date of last booster _____		
_____ Polio (all 3 oral doses)	_____ Mumps	
_____ Measles	_____ Sickle Cell Test	
_____ Rubella (German Measles)	_____ Tuberculin Skin Test	

Does your child have any history of the following diseases or conditions?

_____ Rheumatic Fever		
_____ Heart Murmur. Type? _____		
_____ Bleeding Problems	_____ Diabetes	
_____ Kidney Disease	_____ Chicken Pox	
_____ Seizures	_____ Anemia	
_____ Ear Infections	_____ Asthma	
_____ Cerebral Palsy	_____ Pneumonia	
_____ Liver Disease	_____ Digestive Disorders	
_____ Learning Disabilities. Type? _____		
_____ Emotional Disabilities. Type? _____		
_____ Hearing Difficulty. Type? _____		
_____ Speech Difficulty. Type? _____		

Has your child ever been hospitalized?	Yes	No
If so, when? _____		
For what reason? _____		

Has your child had any operations?	Yes	No
If so, when? _____		
For what reason? _____		

Was general anesthesia used?	Yes	No
Any complications? _____		

