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PATIENT INFORMATION

Name of patient: _____ Nickname: _____

Date of Birth: _____ Age: _____

Mother's Name: _____ Phone # _____

Address: _____ Employer: _____

_____ Work Phone # _____

_____ SS # or Drivers license # _____

Father's Name: _____ Phone # _____

Address: _____ Employer: _____

_____ Work Phone # _____

_____ SS # or Drivers license # _____

Nearest Relative: _____ Phone: _____

Insurance Carrier: _____ Policy # _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Social Security #: _____ Group #: _____

Carrier Contact & Address: _____

Has your child had an exam, cleaning, fluoride treatment or x-rays in the past six months? yes no

Has your choild had restoragive work including fillings this year? yes no

Referred by: _____

MEDICAL HISTORY

Name of your child's pediatrician? _____

Date of last physical? _____

Does your child have any health problems or is your child being treated by a physician? yes no

Is your child taking any medications? If yes, what for? yes no

Is your child allergic to penicillin, antibiotics, or any other drugs? If yes, list below. yes no

Does your child have other allergies? (latex, metals, foods) If yes, list below. yes no

Has your child ever had surgery? If yes, list below. yes no

Does your child have a heart murmur or any other heart related illnesses? If yes, list below. yes no

Does your child experience severe or prolonged bleeding? If yes, list below. yes no

Has your child had a history of any of the following:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Congenital birth | <input type="checkbox"/> Defects Mental Retardation | <input type="checkbox"/> Headaches | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Autism | <input type="checkbox"/> Fainting | <input type="checkbox"/> Seizures |

DENTAL HISTORY

Is this your child's first visit to the dentist? _____ Last visit: _____

Were x-rays taken? yes no Has your child had cavities? yes no

Has your child had problems with dental treatment in the past? yes no

How many snacks a day does your child eat? _____

Does your child use a bottle or "sippy cup"? yes no If not at what age stopped? _____

When does your child brush his/her teeth? _____

Who brushes your child's teeth? _____

Does your child drink juice/milk/soda? yes no How much?: High Moderate Low

Did your child ever go to bed with a bottle? yes no

Has he/she ever fallen and hit their teeth? yes no

When? _____ Where? _____

Does your child grind his/her teeth? yes no

Does your child suck a thumb/finger? yes no

Does your child wear a mouth guard for sports? yes no

FLOURIDE

Do you have city water? yes no

Does your child use fluoridated toothpaste? yes no

Does your child use fluoride drops? yes no