

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ PC : \_\_\_\_\_

Child's Nickname: \_\_\_\_\_ Sex: \_\_\_\_\_ School: \_\_\_\_\_

Name of hobby, sport, toy or playmate special to your child: \_\_\_\_\_

Does child live with both parents? • Yes • No • Mother? • Father? • Guardian?

Parents email: \_\_\_\_\_

**Father(guardian) complete name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Home address (if different from child's): \_\_\_\_\_ Phone: \_\_\_\_\_

• Employed • Homemaker • Student • Retired • Other: \_\_\_\_\_ SIN #: \_\_\_\_\_

Employed by: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Present Position: \_\_\_\_\_ How long? \_\_\_\_\_ Work Phone: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Cert# \_\_\_\_\_

**Mother(guardian) complete name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Home address (if different from child's): \_\_\_\_\_ Phone: \_\_\_\_\_

• Employed • Homemaker • Student • Retired • Other: \_\_\_\_\_ SIN #: \_\_\_\_\_

Employed by: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Present Position: \_\_\_\_\_ How long? \_\_\_\_\_ Work Phone: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Cert# \_\_\_\_\_

Who is responsible for payment? \_\_\_\_\_ Phone number to call about appointments: \_\_\_\_\_

We first learned about this dental office from: • Yellow Pages • Newspaper • School • Work

Referred by: • Another patient/friend • Another patient/relative • Dental office doctor or staff member

• Other: \_\_\_\_\_ Name of person who referred us: \_\_\_\_\_

**DENTAL HISTORY** Is this your child's first visit to the dentist? • Yes • No

Has your child been having any specific problems? • Yes • No Describe: \_\_\_\_\_

Last dental visit: \_\_\_\_\_ Purpose: \_\_\_\_\_ Last complete exam: \_\_\_\_\_

Has your child experienced any unfavorable reaction from any previous dental or medical care? • Yes • No

Specify: \_\_\_\_\_

How would you describe your child's dental health? • Good • Fair • Poor

Do you think your child has active dental disease: Decay? • Yes • No Gum Disease? • Yes • No

Child's home care: Brush? • Yes • No Floss?: • Yes • No Other?: \_\_\_\_\_

Do your child's gums ever bleed? • Yes • No How often?: \_\_\_\_\_ Bad breath? • Yes • No

Does your child have any bad mouth habits? • Yes • No Specify: \_\_\_\_\_

**MEDICAL HISTORY (Confidential. Repeated every 5 years) Birth date**

**(mm/dd/yy):** \_\_\_\_\_

Doctor's name: \_\_\_\_\_ Last physical exam: \_\_\_\_\_ Current age: \_\_\_\_\_

Does your child have any medical problems? • Yes • No Describe: \_\_\_\_\_

Is your child under a doctor's care now? • Yes • No If so, for what reason: \_\_\_\_\_

Is your child taking any medications? • Yes • No Please list: \_\_\_\_\_

- |                       |                 |                |                      |                            |                           |
|-----------------------|-----------------|----------------|----------------------|----------------------------|---------------------------|
| • Heart disease       | • Measles       | • Tonsilitis   | • Hepatitis          | • Epilepsy                 | • Kidney disease/dialysis |
| • Heart murmur        | • Mumps         | • Jaundice     | • Prolonged bleeding | • Fainting                 | • Allergy to medications  |
| • Rheumatic fever     | • Scarlet fever | • Asthma       | • Herpes             | • Seizures/convulsions     | • Anesthetic allergy      |
| • High blood pressure | • Typhoid fever | • Tuberculosis | • AIDS               | • Psychiatric treatment    | • Allergy to foods        |
| • Diabetes            | • Chicken Pox   | • Arthritis    | • Malignancies       | • Prosthetic valves/joints | • Other allergies:        |

List all of your child's allergies here: \_\_\_\_\_

**AUTHORIZATION:** I hereby authorize the doctor and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care of my child as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Child's Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_