PATIENT DEMOGRAPHICS

PATIENT LAST NAME			FIRST NAME	MI
ADDRESS				
CITY	STATE		ZIP	
DOB	AGE	M____ F____	EMAIL	
MOBILE#			HOME #	

PARENT / GUARDIAN INFORMATION

WHO BROUGHT THE PATIENT IN TODAY? NAME	RELATIONSHIP
DO YOU HAVE LEGAL CUSTODY OF THIS PATIENT? Y/N	
ADDRESS (IF DIFFERENT)	
MOTHERS CELL PHONE #	MOTHERS WORK PHONE #
MOTHERS EMAIL	MOTHERS EMPLOYER
FATHER'S NAME	FATHERS DOB
FATHERS ADDRESS (IF DIFFERENT)	
FATHERS CELL PHONE #	FATHERS WORK PHONE #
FATHERS EMAIL	FATHERS EMPLOYER

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE CO.	INSURANCE CO.
POLICYHOLDER'S NAME	POLICYHOLDER'S NAME
RELATION TO PATIENT	RELATION TO PATIENT
SS# OF POLICY HOLDER	SS# OF POLICY HOLDER
DATE OF BIRTH	DATE OF BIRTH
GROUP NAME	GROUP NAME
GROUP NUMBER	GROUP NUMBER

MEDICAL HISTORY

PLEASE INDICATE IF THERE HAS BEEN A HISTORY OF THE FOLLOWING:		
Y / N ABNORMAL BLEEDING	Y / N SICKLE CELL DISEASE	Y / N ASTHMA
Y / N HEART MURMUR	Y / N ADD/ADHD	Y / N HEARING IMPAIRED
Y / N ANY OPERATIONS	Y / N HIV	Y / N MONONUCLEOSIS
Y / N ANY HOSPITAL STAYS	Y / N HEPATITIS	Y / N TUBERCULOSIS
Y / N CHICKEN POX	Y / N MEASLES	Y / N CANCER
Y / N EPILEPSY	Y / N SKIN RASH	Y / N DIABETES
Y / N KIDNEY/LIVER DISEASE	Y / N ANEMIA	Y / N OTHER
PHYSICIAN NAME	PHONE NUMBER	
ARE IMMUNIZATIONS CURRENT?		
IS THERE CURRENTLY ANY CARE UNDER A PHYSICIAN?		
HAS THE PATIENT EVER SEEN A CARDIOLOGIST?		
ARE THERE ANY KNOWN ALLERGIES TO ANY DRUGS, LATEX, METALS?		
PLEASE LIST ALL CURRENT MEDICATIONS?		

DENTAL HISTORY

HAS THERE EVER BEEN A PROBLEM WITH PREVIOUS DENTAL WORK?	Y / N
IS THERE A HISTORY OF PAIN IN THE TMJ JAW JOINT?	Y / N
ARE THERE ANY PROBLEM'S BRUSHING?	Y / N
ARE THERE ANY PROBLEM'S FLOSSING?	Y / N
ARE THERE ANY OF THE FOLLOWING HABITS (LIP BITING, NAIL BITING, BOTTLE, THUMB SUCKING)?	Y / N
MAIN PURPOSE OF TODAY'S VISIT?	

SIGNATURE

I AFFIRM THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES. I AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES MY CHILD MAY NEED. THESE SERVICES MAY INCLUDE A CLEANING, X-RAYS, FLUORIDE TREATMENT, LOCAL ANESTHETICS, ANTIBIOTICS, SEDATION MEDICATIONS, NITROUS OXIDE, REMOVAL OF TEETH, STAINLESS STEEL CROWNS, WHITE ANTERIOR CROWNS, PULPOTOMY NERVE TREATMENT, PAPOOSE SAFETY RESTRAINT, SEALANTS, AND WHITE FILLINGS. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND TO FULLY READ THIS FORM. I CONSENT TO THE PROPOSED TREATMENT.

PARENT / GUARDIAN SIGNATURE	DATE