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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.

____ First Exam
____ Routine Cheek-up
____ Accident
____ Bleeding Gums
____ Cavities
____ Broken Tooth
____ Toothache/Swelling
____ Staining/Discoloration
____ Crowding of Teeth
____ Thumb Habit
____ Other Habits
____ 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? Yes No
   How frequently and when? A.M. P.M. After Snacks Before Bed After Breakfast

6. Do you brush your child's teeth? Yes No
   How frequently and when? A.M. P.M. After Snacks Before Bed After Breakfast

7. Do you floss your child's teeth? Yes No
   How frequently and when? A.M. P.M. After Snacks Before Bed After Breakfast

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

Drug	Dose	Frequency	Reason

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)

_____ Measles

_____ Rubella (German Measles)

_____ Mumps

_____ Sickle Cell Test

_____ Tuberculin Skin Test

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

_____ Rheumatic Fever

_____ Heart Murmur. Type? _____

_____ Bleeding Problems

_____ Kidney Disease

_____ Seizures

_____ Ear Infections

_____ Cerebral Palsy

_____ Liver Disease

_____ Diabetes

_____ Chicken Pox

_____ Anemia

_____ Asthma

_____ Pneumonia

_____ 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? _____

Does your child bruise easily? Yes No

Has there ever been any history of spontaneous bleeding, (e.g., nose bleeds) or prolonged bleeding following tooth removal surgery, cuts, etc.? Yes No

3. Growth and Development:
   - Age child's first tooth noticed _____
   - Age child lost first tooth _____
   - Age first spoke a word _____
   - Age first started to walk _____

   General Development would be: Early Average Late

4. Family History (with whom child resides)
   - Is mother living? Yes No
   - Is father living? Yes No
   - Are parents living together? Yes No
   - Are mother's teeth and gums in good health? Yes No
   - Are fathers teeth and gums in good health? Yes No

5. Remarks: _____

_____

_____

_____

_____

_____

The signature of a parent or guardian affixed below authorizes the completion of all mutually agreed upon necessary dental services.

Signature _____ Relationship _____ Date _____

RE-EVALUATION OF ORIGINAL PATIENT INFORMATION FORM

DATE	NO CHANGE	CHANGES	PARENT INITIAL