

Patient Information

Chart #.
FOR OFFICE USE ONLY

Patient Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: Male Female Family Status: Married Single Child Other

Birth Date: Prev. Visit: Email Address:

Phone: Home Work Ext Mobile Best time to call:

Address:
 City State Zip Code

Responsible Party Information

The following is for: the patient's spouse the person responsible for payment neither-not applicable

Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: Male Female Family Status: Married Single Child Other

Birth Date: SS #: Driver's License #:

Email Address: Best time to call:

Phone: Home Work Ext Mobile Fax Other

Address:
 City State Zip Code

How did you hear about our practice?

Primary Dental Insurance

Name of Insured:
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Secondary Dental Insurance

Name of Insured:
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Medical & Dental History

Your child's current primary care physician name and phone number:

Has your child ever been hospitalized?

Yes No

If so, when and why?

Does your child have or has your child ever had any of the following conditions:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Allergy - Egg | <input type="checkbox"/> Allergy - Food/Dye | <input type="checkbox"/> Allergy - Medication | <input type="checkbox"/> Allergy - Other |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asperger's | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Blind | <input type="checkbox"/> Blood Disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Developmental delay |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> G-Tube Feeding | <input type="checkbox"/> Hearing Loss/Impair | <input type="checkbox"/> Heart Murmur/Defect |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Hyperactivity/ADHD | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Other | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Pre-Med | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Snoring | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> STD(S) | <input type="checkbox"/> Syndrome (Specify) | <input type="checkbox"/> Tuberculosis | |

Please explain all checked responses and any other conditions your child may have:

Is your child currently taking any prescription or non-prescription medications?

Yes No

If yes, please list all medications:

Does your child have any allergies to medications?

Yes No

If yes, please list:

Does your child have any other allergies?

Yes No

If, yes please list:

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

Yes No

If yes, name of previous dentist?

Reason for today's visit (check all that apply):

Check-up Emergency Pain Treatment

How do you think your child will react to this dental visit?

Cooperative Uncooperative Not Sure

To the best of my knowledge, all of the preceding information is true and correct. If my child has a change in their health, I will inform the office at their next dental appointment without fail.

Response Date: