

Patient Information

Date _____ Best Phone # to be Contacted at: _____

Patient's Name _____ Sex: M F
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Father's Name _____ Marital Status _____
Last First Middle

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____

Employer _____ Occupation _____ No. Years Employed _____

Mother's Name _____ Marital Status _____
Last First Middle

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____

Employer _____ Occupation _____ No. Years Employed _____

Insurance Information

Primary Insured's Name _____ Subscriber ID # _____
Last First Middle

Insured's Address _____ Insured's Birthdate _____
Street City State Zip

Insured's Employer _____ Insurance Company _____

Insurance Co. Address _____
Street City State Zip

Insurance Co. Phone No. _____ Group No. _____

Do you have dual coverage? Yes No

Secondary Insured's Name _____ Insured's Social Security # _____
Last First Middle

Insured's Address _____ Insured's Birthdate _____
Street City State Zip

Insured's Employer _____ Insurance Company _____

Insurance Co. Address _____
Street City State Zip

Insurance Co. Phone No. _____ Group No. _____

Emergency Information

Name of nearest relative not living with you _____ Phone _____
Last First Middle

Complete Address _____
Street City State Zip

I agree to pay the estimated patient portion at the time of service and will be financially responsible for any portion not paid by the insurance company.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

MEDICAL/DENTAL HISTORY

Name of physician or pediatrician _____ Phone _____

Name of last dentist seen by child _____ Phone _____

HEALTH AND DISEASES: Has the child any history of the following conditions? (Circle those which apply)

ALLERGIES	ANEMIA	ASTHMA	BLEEDING PROBLEMS
CANCER	CONVULSIONS	DIABETES	EMOTIONAL PROBLEMS
EPILEPSY	FUNCTIONAL HEART MURMUR	HEARING PROBLEMS	HEART DISEASE
HIGH FEVERS	HIV OR AIDS	KIDNEY DISEASE	LIVER DISEASE
MENTAL PROBLEMS	HOSPITALIZATION	RHEUMATIC FEVER	SEVERE INFECTIONS
SPEECH PROBLEMS	ORGANIC HEART MURMUR	TUBERCULOSIS	TUMORS
VENEREAL DISEASE	SURGERY	PREGNANCY	HEPATITIS

OTHER: _____

IMMUNIZATIONS: Up to date YES NO

Present Dental Complaint: _____

Child's Height: _____ Child's Weight: _____ Eat: Well Poorly Sleep: Well Poorly

IS THE CHILD

Required to take an antibiotic premedication because of heart disease? YES NO

Under a physician's care? YES NO WHY? _____

Taking any medications? YES NO FOR WHAT? _____

Allergic to any medications? YES NO WHAT? _____

Having any health problems? YES NO WHAT? _____

Allergic to anything else? YES NO WHAT? _____

A finger or thumb sucker? YES NO WHICH ONE? _____

Have Tonsils and Adenoids been removed? YES NO (At what age? _____)

Is the patient a mouth breather? YES NO

Does the patient play a musical instrument? YES NO WHICH? _____

Visiting the dentist for the first time? YES NO

Reason for today's visit? _____

Taking fluoride supplements? YES NO IF NOT, WHY? _____

HAS THE CHILD

Had an unfavorable dental experience? YES NO

Explain _____

Had any teeth extracted YES NO

Had a severe mouth infection or injury? YES NO

Had a space maintainer placed? YES NO

Do you know of any dental problems your child has?

Are there any problems not listed above which you feel the doctor should know about?

I hereby grant permission for dental work to be performed on this minor and will assume all responsibilities connected with such treatment.

Signature _____

Treatment Plan for Hospital Case (to be filled out by dental staff)

Tx Time: _____

Diagnosis: _____

Tooth	Services Necessary	Tooth	Services Necessary
1	_____	11	_____
2	_____	12	_____
3	_____	13	_____
4	_____	14	_____
5	_____	15	_____
6	_____	16	_____
7	_____	17	_____
8	_____	18	_____
9	_____	19	_____
10	_____	20	_____