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About Your Child

Child's Name: \_\_\_\_\_  
 Child's SS #: \_\_\_\_\_  
 Sex: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_

Other Information

WHO CAN WE THANK FOR  
 REFERRING YOU TO US?  
 \_\_\_\_\_  
 \_\_\_\_\_

Other children's names and ages:  
 \_\_\_\_\_  
 \_\_\_\_\_

Have we seen any other family  
 members before?  
 \_\_\_\_\_  
 \_\_\_\_\_

Insurance Information

Do you have Dental Insurance?  
 \_\_\_\_\_

If yes, who is the carrier and who  
 is it through?  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have Medicaid?  
 \_\_\_\_\_  
 \_\_\_\_\_

Dad's Information

Name: \_\_\_\_\_  
 Marital Status: S M W D Sep  
 Address(If different from above): \_\_\_\_\_  
 DL #: \_\_\_\_\_  
 SS #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Cell Phone#: \_\_\_\_\_  
 Home Phone#: \_\_\_\_\_  
 Employer & Work #: \_\_\_\_\_

Mom's Information

Name: \_\_\_\_\_  
 Marital Status: S M W D Sep  
 Address(If different from above): \_\_\_\_\_  
 DL #: \_\_\_\_\_  
 SS #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Cell Phone#: \_\_\_\_\_  
 Home Phone#: \_\_\_\_\_  
 Employer & Work #: \_\_\_\_\_

Child's History

Date of Child's last dental visit: \_\_\_\_\_  
 Any injuries to the mouth or teeth? \_\_\_\_\_  
 Is child under care of physician now? Yes or No  
 Is child taking any medications? Yes or No  
 Is child allergic to any medications? Yes or No  
Has your child had any history of the following?

Reason for visit: \_\_\_\_\_  
 Mouth habits: thumb sucking    nail biting    mouth breathing  
 Child's Pediatrician: \_\_\_\_\_  
 If so please list medications: \_\_\_\_\_  
 If so please list medications: \_\_\_\_\_

Y / N Anemia	Y / N Allergies	Y / N Asthma	Y / N CP	Y / N Kidney	Y / N Rheumatic Fever
Y / N Epilepsy	Y / N Fainting	Y / N Heart	Y / N Liver	Y / N Diabetes	Y / N Mononucleosis
Y / N Thyroid	Y / N HIV/AIDS	Y / N Mumps	Y / N Measles	Y / N Malignancies	Y / N Convulsions
Y / N Pregnant	Y / N Hearing	Y / N Chronic Sinusitis	Y / N Mental Retardation		

Any other dental or medical problems or concerns? \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_